URBIS

WELLBEING AND HEALTH IN-REACH NURSE (WHIN) COORDINATOR MODEL PILOT EVALUATION

Final

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ACRONYMS

Acronym	Description
ADHD	Attention Deficit Hyperactivity Disorder
GP	General Practitioner
LHD	Local Health District
NSW	New South Wales
WHIN	Wellbeing Health In-reach Nurse
WPMT	WHIN Program Management Tool
YMCA	Young Men's Christian Association

EXECUTIVE SUMMARY

BACKGROUND AND METHODOLOGY

The Wellbeing and Health In-Reach Nurse (WHIN) Coordinator Model was piloted from 2018 to 2020 at three sites across NSW – Young, Tumut, and Cooma. In mid-2018, Urbis was commissioned by the NSW Ministry of Health to undertake a formative evaluation of the Pilot. The Urbis evaluation methodology includes three waves of research:

- Wave 1 in November-December 2018 (with reporting in December 2018)
- Wave 2 in May-June 2019 (with reporting in August 2019)
- Wave 3 in August-September 2020 (with reporting in December 2020). This wave was delayed due to COVID-19 restrictions.

This report presents findings for the entire evaluation of the Pilot from July 2018 to September 2020 and draws on research and analysis conducted throughout the evaluation. Data sources for the evaluation comprised the following elements:

- Interviews with WHIN Coordinators (n=9)
- Interviews with School Executives and staff (n=54)
- Interviews and focus groups with health and community service providers (n=27)
- Interviews with parents and family members (n=5)
- Focus groups with young people (n=30)
- Focus group with Ministry stakeholders (n=8)
- Feedback from Department of Education staff (n=2)
- A review of service and education data

WHIN Coordinators and some School Executives and staff were interviewed multiple times across the three waves of data collection. Using all available data sources, a thematic analysis of the evidence was undertaken to identify findings. These findings have been presented as Pilot implementation and governance, service access and experience, evidence of impact, and considerations for sustainability and scalability. An evaluation assessment and recommendations for Model improvement are also included.

SUMMARY OF FINDINGS

A novel approach to supporting the health and wellbeing of children and young people was tested with the introduction of the WHIN Coordinator Model Pilot in Young in February 2018, and in Cooma and Tumut in July 2018. While the addition of a health professional to school campuses has not always been easy, the WHIN Coordinators have been successful in providing tailored care and support to nearly 800 people over two years. Upon Pilot inception, it was anticipated that WHIN Coordinators would primarily offer prevention and early intervention services; however, they have played a role managing complex cases, including students experiencing severe mental health issues, sexual assault, and suicide of family members. This highlights a need for a clear Scope of Practice and robust clinical governance processes, as well as a support system for the WHIN Coordinators, who are collocated in schools and predominantly work outside health settings. An overview of the Pilot's key achievements, barriers to success, and enablers for sustainability and scalability are provided below.

Key achievements

The WHIN Coordinator Model Pilot has made significant progress and experienced success establishing the Model within schools, supporting students and families to achieve positive health and education outcomes, and linking school and community health and wellbeing interventions. These achievements are outlined below.

The WHIN Coordinator Model became embedded in schools and communities

At all three sites, there are examples where the WHIN Coordinator Model were successfully integrated into schools within the community. WHIN Coordinators have established their role within local schools, regularly attend school wellbeing and interagency meetings, and built relationships with schools and local health and community service providers. Many School Executives have championed the inclusion of the Coordinator in their schools, supporting WHIN Coordinators to integrate with their wellbeing systems and providing opportunities to socialise the Model with staff. These activities have supported WHIN Coordinators to become embedded in schools and the local service system.

Students and their families access the WHIN Coordinators

During the Pilot, students and their families continued to access WHIN Coordinators through a variety of referral pathways. Sites demonstrate demand for the WHIN Coordinator's services with more than 750 instances of service during the Pilot over 1 March 2018 – 31 July 2020. The demand was driven mainly by referrals from school staff (78%), followed by self-referrals by secondary students (17%), and referrals from parents (15%). A small number of referrals (4%) came from community organisations. This cumulative demand indicates that the service continues to be accessible and utilised by students and families.

The WHIN Coordinator Model contributed to improved health and education outcomes for students

Consultation feedback and program data suggest that students who have been supported by a WHIN Coordinator experience improved health and education outcomes. Feedback from stakeholders highlights that WHIN Coordinators supported many students and families to access care for health and wellbeing needs that they otherwise would not have received. In addition, students who accessed the WHIN Coordinator lost less class time to absences, which the literature correlates with educational achievement. This evidence suggests the WHIN Coordinator Model has a positive impact on the health, wellbeing, and education of the students it supports.

Students and families were supported to access health and wellbeing services

The WHIN Coordinator has assisted students and families to connect with local services to support their health and wellbeing. Between 1 March 2018 and July 21 2020, 150 students were referred to primary health care (including GPs, pharmacists, or allied health professionals) and 144 were referred to mental health services to address health needs. In addition, 176 students connected with social services for support with non-health related issues. The WHIN Coordinators enabled this access to services by assisting students and their families to identify, navigate, and remain connected to the health and social service system. This was particularly true for vulnerable families who often lacked the health literacy to understand or navigate the health system independently.

WHIN Coordinators connect schools with and health and social service systems

The evidence indicates that WHIN Coordinators act as a conduit between school and health and social services to ensure students and families receive the support they need. WHIN Coordinators utilised their relationships with school and health and social services to connect students with relevant services and ensure these services have a shared understanding of a student's context and needs. This allowed WHIN Coordinators to ensure that students received holistic, relevant support.

Schools and communities recognised the value of the WHIN Coordinator role

School and community stakeholders expressed how highly they value the role of the WHIN Coordinators. School stakeholders appreciated that WHIN Coordinators had diverse expertise which improved assessment of student behaviour and care coordination, enabling school wellbeing staff to focus on other priorities such as counselling. Community stakeholders perceived the WHIN Coordinator's role as critical in strengthening their relationship with schools and connecting students with support services.

Barriers to success

While the WHIN Coordinator Model has been broadly successful, consistency in understanding of the WHIN Coordinator's role, and challenges integrating health professionals in school environments have posed barriers to the Model's implementation. These barriers are outlined below.

Inconsistency in understanding of the WHIN Coordinator's role, scope and boundaries

Evidence suggests that while the WHIN Coordinator role became more clearly understood, some inconsistency in understanding the role remained. Some school staff showed a poor understanding of the WHIN Coordinator's role, suggesting that it was not well integrated with the school's teaching and wellbeing system. This suggests that while the Model can be effective if the role of the WHIN Coordinator is not understood by school staff and is not well integrated within a school, implementation is adversely impacted.

Insufficient support to integrate a health professional in an education setting

Stakeholder experiences suggest that it takes time to integrate a WHIN Coordinator within an education setting. Time is required for WHIN Coordinators to learn education policies and procedures, as well as the systems and processes specific to each school. As not all WHIN Coordinators were provided with a comprehensive orientation to the individual schools during the establishment phase, it took considerable time and effort to learn how to operate within the school environment. This led to some instances where a WHIN Coordinator's actions did not align with school expectations, such as not providing student information to another staff member. The extended period it took WHIN Coordinators to adapt to an education setting may have contributed to the inconsistent understanding of the role of the WHIN Coordinator within a school.

Enablers for sustainability and scalability

As with most Pilots, there have been significant learnings related to Model design and governance through this early stage of implementation. These enablers for success and sustainability are outlined below.

The WHIN Model is well placed to achieve health and education outcomes by positioning the WHIN Coordinator as a school-based wellbeing nurse who works across the community

The evidence suggests that for the WHIN Coordinator Model to continue to be successful, the role should be a school-based 'wellbeing nurse' who adopts a holistic and comprehensive approach to the health of children, young people and families. This includes a WHIN Coordinator with knowledge and experience in child and family health, paediatrics or youth health, and the capacity and capability to work within a community-based non-health setting.

Service delivery is most effective when underpinned by strong relationships with students, school stakeholders, and community services

The evidence suggests that a relational-based service delivery model underpins the Model. Maintaining strong relationships within and between school and service systems, as well as with students and families is therefore critical to ongoing success and scalability.

A partnership approach to Model management should articulate expectations, governance, and lines of accountability

It is critical for success that the Model is underpinned by a robust partnership between NSW Health and the NSW Department of Education stakeholders at all levels of governance (whole-of-Model, site and school). The evidence indicates this works best when expectations, decision-making and accountability structures are clearly defined at each level, and all relevant stakeholders are actively involved in Model management.

EVALUATION ASSESSMENT

Table 1 – Evaluation assessment of the WHIN Coordinator Model Pilot

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
Foundational Activities	
Management and Governance Establish Steering Committee and governance arrangements; set out the collaborative relationship between NSW Health and the NSW Department of Education, set model of care and service delivery model(s); develop key performance indicators (KPIs) and mechanisms for reporting against KPIs (throughput, referral rates, and so on)	**Mostly achieving** ▪ Management and governance frameworks are established at a whole-of-Model, site, and school level ▪ Accountability has improved during the Pilot, but the effectiveness of governance frameworks varies across the sites
Implementation Develop scope of practice for WHIN Coordinators; engage stakeholders and hire WHIN Coordinators; establish work environments and resources, establish occupational health and safety, and insurance arrangements, engage local stakeholders	**Partly Achieving** ▪ All WHIN Coordinators positions are filled, staff are operating from established work environments, and have engaged with local stakeholders ▪ Integration and compatibility of data and technology between the Health and Education systems continue to impede the WHIN Coordinator's ability to fulfil their role.
Outputs	
Partnerships established with local schools and service providers	**Achieving** ▪ Partnerships between WHIN Coordinators and schools and local service providers have been established at all sites
Students referred to WHIN Coordinator	**Achieving** ▪ All WHIN Coordinators receive referrals via formal and informal mechanisms, continuously.
Students (and families) triaged and connected with local service providers	**Achieving** ▪ All WHIN Coordinators assessed the needs of students and families and connected them with local service providers.
WHIN Coordinator provides opportunistic health education and promotion to school communities (one-on-one and group; not in classroom)	**Achieving** ▪ All WHIN Coordinators provide health education and promotion through both formal and informal channels
Short term outcomes	
Increased access to health and social services by students and families	**Achieving** ▪ Many students and families accessed health and social services with support from the WHIN Coordinator, where otherwise they would have been unable
The WHIN Coordinator Model has been successfully incorporated into a whole-of-school approach to student wellbeing (as available)	**Mostly achieving** ▪ Schools have integrated the WHIN Coordinator Model with existing wellbeing systems, but the clarity and

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
	consistency of role with these systems varies across sites.
Student (and family) health and wellbeing needs are identified	**Achieving** ▪ All WHIN Coordinators frequently identified health and wellbeing needs of students and families. ▪ Students presented most frequently to the WHIN Coordinator for mental health concerns (246 instances), social support (222 instances), and behavioural symptoms (126 instances)
Students (and families) access affordable and appropriate local services and programs	**Achieving** ▪ WHIN Coordinators connected students and families with social services (176 instances), primary health care (150 instances), and mental health care (144 instances). ▪ Unexpected factors, such as reduced service availability due to COVID-19, prevented WHIN Coordinators from supporting some students and families to access appropriate services and programs.
Student (and family) health and wellbeing needs are addressed on an ongoing basis	**Insufficient evidence available** ▪ Two-thirds of referrals to the WHIN Coordinator were resolved within two months. ▪ Qualitative evidence suggests that WHIN Coordinators had a brief intervention with most students and families to triage the case and provide a warm referral to an appropriate service. In the context of the Model, this was an appropriate response. ▪ No evidence is available to measure student and family's ongoing engagement with services.
Students are motivated to participate and engage in school	**Mostly achieving** ▪ Qualitative evidence suggests that WHIN Coordinators mostly support students to overcome health and other barriers to participating and engaging in school.
Parents are able to support students to achieve positive health and education outcomes	**Insufficient evidence available.**
Intermediate outcomes	
Positive health and education outcomes for students and families	**Emerging evidence** ▪ Qualitative evidence suggests the WHIN Coordinator supports many students and families to address health and wellbeing needs that they would otherwise be unable to resolve. ▪ Qualitative and quantitative evidence suggests that students who access the WHIN Coordinator experience improved attendance and engagement with school, which the literature correlates with improved education outcomes. ▪ Case studies of a sample of students and families supported by the WHIN Coordinators demonstrate that

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
	positive health and education outcomes have been achieved
Local health and human services provide coordinated care to student and families	**Mostly achieving** ▪ Qualitative evidence indicates that WHIN Coordinators often connected school and community service systems to ensure students and families received holistic support.
School teachers and leadership devote less time to case management	**Sometimes achieving** ▪ Qualitative evidence suggests that in some instances, WHIN Coordinators enabled school staff to reduce their case management workload.
Student health and wellbeing is improved	**Early evidence** ▪ Qualitative evidence suggests that many students who engaged with the WHIN Coordinator experienced improved health and wellbeing.
Students are engaged and participating in school	**Early evidence** ▪ Qualitative evidence suggests that WHIN Coordinators support students to participate and engage in school by addressing health and other barriers to school engagement and participation. ▪ The sample of student attendance data analysed showed that while the attendance rates decreased after a WHIN intervention, there was a substantial reduction in the amount of time students were absent for unexplained reasons (82% reduction), illness (70% reduction), and approved reasons (58% reduction).
Students have a sense of connectedness and belonging to the school community	**Insufficient evidence available** ▪ Anecdotal reports suggest some students feel a sense of connectedness and belonging to the Care Connect Hub in Young.
Vulnerable students and families are physically and emotionally safe	**Early evidence** ▪ Qualitative evidence suggests vulnerable students and families supported by WHIN Coordinators to access health and social services showed improvement in their physical and emotional safety, but further evidence is required.
Long-term outcomes	
Optimal health and wellbeing outcomes for children and young people	Outside scope of evaluation
Optimal education outcomes for children and young people	Outside scope of evaluation
Impact	
Children and young people are safe and achieving their full potential	Outside scope of evaluation

RECOMMENDATIONS

Drawing together evidence collected for this evaluation and the assessment above, we put forward the following recommendations for the ongoing implementation of the WHIN Coordinator Model. Two further points should be noted:

(a) These recommendations were developed with the knowledge that since the introduction of the Pilot, the Model has been expanded to a further three sites. In addition, in November 2020, the NSW Government has announced that the program would be expanded to create 100 new WHIN Coordinator positions.
(b) When making decisions about the future of the Model, attention should also be given to the considerations for sustainability and scalability included in Section Five of this report.

Recommendation one: The Ministry and Department of Education should undertake a detailed operational review of existing sites.

This should assess the performance and operation of each Pilot site to determine fidelity to the success enablers identified in this evaluation. Where necessary, local adjustments to the Model should be made at each site to improve implementation success and outcomes achieved.

Recommendation two: The Ministry and Department of Education should undertake a review of governance at whole-of-Model, site, and school level.

This should assess performance in terms of the following factors and adjust as necessary:

- Membership, roles, and responsibilities of governance groups
- Monitoring and reporting of Model performance
- Management of clinical and operational risk

Recommendation three: The Ministry and Department of Education should review the model of care and service delivery model based on evaluation findings and update as necessary.

This process should, at a minimum, include the following key steps:

- Undertake a Model review process using evaluation findings to adjust:
  - the program logic, indicators of success, and model of care to reflect the outcomes which the evidence suggests the program can be expected to achieve (i.e. is it reasonable to expect the program to address student (and family) health and wellbeing needs an ongoing basis)
  - governance and reporting processes to ensure quantitative evidence for the Model's impact on education and health outcomes is collected (i.e. collecting data on school attendance and ongoing engagement or discharge from health or social services) and
  - Model guidelines and partnership arrangements for roles, responsibilities, and delegations of authority
- Develop an approach to collect and link Model-specific health and education data to improve the measurement and evaluation of outcomes
- Distribute comprehensive documentation of an tweaks to the Model (including program logic, indicators of success, model of care, governance and reporting arrangements, suggested integration with existing systems) to provide clarity and support sites and schools make local adjustments to respond to local context.

Recommendation four: The Ministry and Department of Education should develop an implementation strategy to guide the establishment phase for any new sites to ensure lessons from the formative evaluation are applied.

This Strategy should include the adoption of 'testing phase', to assess potential new sites for feasibility and readiness before commencing any establishment processes, with the option of not proceeding with establishment if the site is not currently suitable or set up for success.

In addition, as the program expands monitoring and evaluation processes will be critical to supporting the success of the program. Incorporating evaluative thinking into the implementation and delivery of an expanded Model will support the Steering Committee and Local Governance Committees to make evidence-informed decisions. Further, commissioning a process evaluation in parallel to Model expansion will provide the Steering Committee with independent analysis and advice to inform ongoing implementation. The Steering Committee may also consider commissioning an operational review of new sites to ensure local adjustments adhere to the Operating Guidelines.

1. INTRODUCTION

1.1. BACKGROUND

In 2018 the NSW Cabinet Standing Committee on Social Policy endorsed the implementation of the Wellbeing and Health In-Reach Nurse (WHIN) Coordinator Model in three Pilot sites in NSW – Young, Tumut and Cooma.

The connection between health and education outcomes is well established (WHO, 2006). Healthy children are better learners (Basch, 2011) and better health outcomes over a lifetime are influenced by higher educational achievement (OECD, 2006). Further, student health and wellbeing can be substantially affected by the school environment, and health-promoting schools can take advantage of this by integrating health and wellbeing activities into the school community (WHO, 2006). Within schools, health and education professionals have mutually beneficial roles in securing better health and education outcomes for children and young people. Schools can take various steps to nurture student wellbeing, including:

- providing a safe physical and emotional environment
- promoting pro-social values
- nurturing a supporting and caring community
- providing social and emotional learning opportunities
- encouraging healthy lifestyles
- adopting a strength-based approach to education and activities
- fostering a sense of meaning and purpose in life. (WA Department of Health, 2020)

The NSW Government recognises the relationship between health and education systems to improve outcomes for children and young people and seeks to strengthen these outcomes through the implementation of a series of health and education policies. These include:

- NSW Premier's Priorities
- NSW Wellbeing Framework for Schools
- NSW Youth Health Framework 2017-24
- NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022
- First 2000 Days Framework
- NSW Health Strategic Framework for Integrating Care
- Value-based healthcare framework

1.2. SCHOOL-BASED HEALTH AND WELLBEING PROGRAMS

A scan of the available evidence for school-based health and wellbeing programs highlights key learnings from these programs. The literature suggests that such programs support student's health and wellbeing, and improve health, wellbeing, and education outcomes. The literature identified programs must be well integrated with the school setting, with strong governance processes and appropriate resourcing. These findings are discussed in detail below.

School-based health and wellbeing programs support student health and wellbeing in various ways

School nurse programs play a key role in the health and wellbeing of students and their families. The literature indicates that health professionals based on school campuses can deliver health and wellbeing outcomes for students (Barnes, Courtney, Pratt, & Walsh, 2004). School nurses undertake a variety of tasks to achieve this, including:

- being a primary contact for physical and mental health issues of students and their families
- connecting students and their families with health services in the local area
- encouraging students to increase their engagement and participation in their education and health (Maughan, 2016; Turner & Mackay, 2015).

The literature reveals that school nurses are often frequent touchpoint for students with a health professional (Maughan, 2016). Health professionals in schools are available to identify, triage physical and mental health issues and connect students and their families with appropriate services for their needs (Tang, et al., 2009). School nurse programs also play a vital role in facilitating access to health and social services (Turner & Mackay, 2015). These programs are able to provide students and families with transport to services,

education and support to navigate the system, and encouragement, where needed, to use these services (Mastorgiannis, 2013; Knopf, et al., 2016) Health professionals in school environments therefore can assist in breaking down barriers (such as transport, costs, inconvenience, trust) some students experience in accessing support (Spratt et al, 2010), particularly for at-risk groups of students (Cope, 2015).

High quality health programs on school sites can ensure students are informed about and feel safe to access quality health services as required, and that these services are integrated within the school community. School nurses typically play a role in ensuring this outcome, as they are 'unique professionals with effective communication and interpersonal skills supported by training and service delivery methods' (Turner & Mackay, 2015). Furthermore, students benefit from accessing school nurses within the familiar school environment which reduces barriers to access by improving individual and community acceptance, particularly amongst at-risk groups (Office of Disease Prevention and Health Promotion, 2020; Avery, Johnson, & Cousins, 2013)

Furthermore, evidence suggests that health professionals can facilitate a meaningful connection between education and health systems (School Nurses Association of New South Wales, 2018). This is achieved through liaising with school staff to understand the students' needs and working with external services to ensure students receive appropriate support for their needs (Knopf, et al., 2016). Ongoing communication and check-ins with all stakeholders involved in the care of the student (both school staff and community service stakeholders) further encourages the interaction between the school and local service settings (Barnes, Courtney, Pratt, & Walsh, 2004; Moore, et al., 2014; Tang, et al., 2009). Consequently, school nurse programs can function as a conduit between the school community and the broader health system by integrating health service delivery in the school setting (Office of Disease Prevention and Health Promotion, 2020).

School nurse programs have also been shown to support students' engagement and participation at school by addressing their health and wellbeing issues. This includes assisting at-risk and vulnerable students in overcoming mental or physical health and wellbeing issues so that they may focus greater attention on their education (Avery, Johnson, & Cousins, 2013; Basch, 2011; World Health Organization, 2014). This is achieved through supporting students and their families in overcoming barriers to their education (such as mental health issues, behavioural issues, physical injury and family issues) and ensuring students feel supported in the broader school community (Hahn & Truman, 2015; Kolbe, 2019; Maughan, 2016). The evidence, therefore, suggests school-based nurses can fulfil various roles including health professionals, mentors and care coordinators that provide ongoing support to students and their families.

Health professionals on school sites support improved health, wellbeing, and education outcomes

The evidence highlights that school-based health and wellbeing programs can support improved health, wellbeing and education outcomes for children and young people. This can be achieved by health professionals delivering onsite health services, such as health assessments and diagnoses, and assistance in responding to acute mental health episodes or physical injury (Avery, Johnson, & Cousins, 2013; Cope, 2015). As discussed above, health professionals in the school setting play a critical role in removing barriers to service access (such as transport, inconvenience, and trust), which supports increased access to services. For example, by providing key navigational advice to students, health professionals in school settings can overcome the complexity of the health system, which can prevent students experiencing multiple disadvantages from accessing care (Robards, et al., 2019).

School nurses, in particular, have also been shown to contribute to positive mental and physical health outcomes of students. One school nurse program in Queensland for example was shown to contribute to significant improvements in the health outcomes of students by helping them engage with health professionals at a more convenient and accessible location (Baigrie, 2011). Further literature highlights the various outcomes school-based health and wellbeing programs can contribute to, such as:

- marked improvements in reducing obesity amongst students via nurse-led intervention (Rajabi Alashti, 2017)
- improved mental health outcomes of students, particularly when supported to access mental health services in the community (Williams, Vaisey, Patton, & Lena, 2020; Spratt et al, 2010; Turner & Mackay, 2015)
- improvement in health literacy and access to support for young people with multiple vulnerabilities (Robards et al., 2019)
- assistance with self-management for students with chronic illness (McCabe, 2020)
- increased early intervention and identification of students at-risk of mental health issues (Allison, Nativio, Mitchell, Yuhasz, 2013; Lewis, Bear, 2000) and substance use amongst adolescents (Pirskanen, Laukkanen, Pietila, 2007).

These improved health outcomes can contribute to students' improved engagement with their education. As noted above, it has been shown that healthier students are better learners (Basch, 2011). The literature also suggests this can foster improved long-term health outcomes, as higher educational achievement can be associated with better health of students and their families over their lifetime (Feinstein, Sabate, Anderson, Sorhaindo, & Hammond, 2006).

Successful school-based health and wellbeing programs have clear governance arrangements, integration within school and community settings and adequate resourcing

The literature highlights several key elements that promote the success of school-based health and wellbeing programs, including fostering health promotion in schools, supporting integration between local services and schools, and adequate resourcing with ongoing training for nurses and school staff.

For example, health and wellbeing programs are more likely to be successful in 'Health Promoting Schools'. That is schools which strengthen their capacity as a health setting (World Health Organisation, 2020; Tang, et al., 2009). Key features of health-promoting schools have been identified across multiple jurisdictions and studies:

1. Developing community partnerships, such as engaging health, education, and community leaders in promotion of health and wellbeing.
2. Implementing health promoting policies and practices, with clear roles and resources for staff.
3. Providing skills-based health education which may include practical health skills such as planning exercise or mental health action plans.
4. Providing socially, mentally, and physically supportive environments.
5. Providing access to health services and improving the health of community (Tang, et al., 2009).

Supporting the integration of health professionals within schools and local services is identified as a key success factor in the literature. The Australian Medical Association highlights that dialogue, collaboration and education between local services and schools are crucial to the successful integration of health programs in school and community settings (AMA, 2014). Kolbe (2019) further identifies collaboration as a critical component of effective school health programs, suggesting. health professionals in schools should have strong relationships and ongoing interaction with both schools and local services (Kolbe, 2019).

The literature also revealed the importance of ensuring that school-based nurse programs are adequately resourced to meet demand. A systematic review of nurse programs in the United Kingdom highlighted that adequate resourcing and training of staff is critical to success (Turner & Mackay, 2015). This primarily involves ensuring that nurses and school staff have relevant training and resources to support program implementation. It also involves outlining clear policies and responsibilities for reporting and responding to health issues (Turner & Mackay, 2015; Tang, et al., 2009; Barnes, Courtney, Pratt, & Walsh, 2004; School Nurses Association of New South Wales, 2018).

1.3. THE WHIN COORDINATOR MODEL PILOT

1.3.1. Pilot objectives

The WHIN Coordinator Model Pilot aims to address the unmet health and social needs of school students to ensure that children and young people are safe and achieving to their full potential. This was intended to be achieved by:

- giving students a sense of belonging to the school community
- improving student wellbeing and health-seeking behaviour
- improving the emotional and physical safety of vulnerable students
- improving health and social service pathways for young people and families.

The Model also aimed to address service access challenges that exist in rural areas, as well as positively impact the health and wellbeing of other family members, especially parents. These outcomes are shown in detail in the WHIN Coordinator Program Logic (see Appendix A).

1.3.2. Pilot delivery

The WHIN Coordinator Model Pilot is a collaborative partnership between NSW Health and the Department of Education (the Department), with development and early establishment of the Model supported by the Department of Communities and Justice, and the Department of Premier and Cabinet. The Model was piloted at three sites across two Local Health Districts (LHDs): Young (Murrumbidgee LHD), Tumut (Murrumbidgee LHD) and Cooma (Southern NSW LHD). The Pilot in Young was established in February 2018, and the Pilots in Tumut and Cooma were established in July 2018. The Pilot in Young was initially funded until December 2019, with Pilots in Tumut and Cooma initially funded until June 2020. Funding of all three Pilot sites has been extended until June 2023.

The WHIN Coordinator is an experienced registered nurse, employed at a Clinical Nurse Specialist Grade 2 grade, who supports the health and wellbeing needs of vulnerable school students and their families and coordinates appropriate assessments and referral to health and social services. Tasks undertaken by the WHIN Coordinator include supporting local partnerships, identifying, and triaging health needs of children, young people and families to refer for appropriate assessments, and developing referral pathways into relevant health and social services. All WHIN Coordinators are employed by NSW Health under the Public Health System Nurses' and Midwives' (state) Award 2018. Funds for WHIN Coordinators employed in Tumut and Cooma were initially provided by Snowy-Hydro, while funds for the Young position were provided by the NSW Health and funding from July 2019 provided by the NSW Government for all sites.

1.3.3. This project

In mid-2018, Urbis was commissioned by the Ministry of Health (the ‘Ministry’) to undertake a formative evaluation of the WHIN Coordinator Model Pilot. The Urbis evaluation methodology includes three waves of research:

- Wave 1 in November-December 2018 (with reporting in December 2018)
- Wave 2 in May-June 2019 (with reporting in August 2019)
- Wave 3 in August-September 2020 (with reporting in December 2020).

These data collection periods were selected to:

- allow for an assessment of Model implementation and the short to medium-term outcomes, including the capturing of key learnings from Pilot sites
- enable adequate time for evaluation planning and primary data collection and sufficient establishment time to allow participation in the Pilot.

The final wave of research was initially planned to occur in May-June 2020 but was delayed due to the impact of COVID-19 global pandemic. This report presents findings for the entire period of the Pilot from July 2018 to September 2020 and draws on research and analysis conducted throughout the evaluation.

1.3.4. Interim evaluation findings

Following the first wave of data collection, Urbis prepared an Interim Report in December 2018 to reflect on the establishment and early implementation of the Pilot. At this early stage, stakeholder consultation indicated a high level of satisfaction with the role and optimism for its potential. The first Interim Report highlighted that the implementation process and the services offered at each site varied slightly, with the Model being influenced by local community needs, the WHIN Coordinator's prior experience, and service delivery arrangements within schools. The evidence from the early implementation phase of the WHIN Coordinator pilot suggested that the common enablers which assist in the introduction of such a role within the school environment include:

- ensuring the schools have adequate time to prepare prior to Model introduction
- active consultation with school counsellors
- clear and shared vision for the role's purpose
- extensive communication of the role's purpose to parents and students, school staff, and local service providers.

The most significant implementation barrier highlighted in Interim Report One was that the pilot would be improved by establishing consistent data collection mechanisms across sites. At the time, data collection methods were inconsistent and did not allow for comparison of service provision across sites. As a result, the Ministry commissioned Urbis to develop the WHIN Performance Management Tool (WPMT), which allowed relevant demographic and service delivery data to be collected to analyse the effectiveness and reach of the Pilot.

A second Interim Report was prepared in August 2019 to reflect on implementation progress and emerging outcomes. At this point, stakeholder feedback and analysis of program data suggested that the Model was having a positive impact on the ability of schools to support students improve their health, wellbeing, and education outcomes. Feedback from consultations suggested implementation of the WHIN Coordinator Model has been supported by five key enablers:

- the WHIN Coordinator's independence from the education system, enabling positive engagement with students and families
- the confidential referral process and private workspaces
- engaged school leadership, who 'champion' the Model and make appropriate changes to policies and procedures to integrate health and education systems at a school level
- supporting WHIN Coordinators to operate within a school environment
- limiting the number of schools which the WHIN Coordinator supports, allowing them to build deeper relationships with school staff.

However, Interim Report Two also highlighted significant barriers to implementation, particularly in relation to consistency in the implementation of the Model, robust governance processes, and the limited orientation for WHIN Coordinators to the education system. As such, the second Interim Report suggested that the Steering Committee:

- provide a comprehensive orientation for WHIN Coordinators, including introductions to NSW Education OHS and privacy policies, NSW Education and school-specific health and wellbeing systems (including roles of teaching staff, school counsellors etc.), and the Professional Experience Framework for teachers,
- develop a formal service delivery model which documents key aspects of the Model, to assist in ensuring the enablers of success are consistently incorporated across the program, without limiting the flexibility to tailor the Model to meet local community needs,
- strengthen governance processes, so NSW Health and the Department of Education are consistently represented within whole-of-program, site, and school governance, with clear lines of accountability and defined resolution processes.

In response, the Steering Committee developed Operational Guidelines for the WHIN Coordinator Model and a Memorandum of Understanding between the NSW Ministry of Health and the NSW Department of Education, to guide governance, implementation, and collaboration. The Operation Guidelines outline the roles, responsibilities, and expectations of all stakeholders for the implementation and delivery of the program. The guidelines also outline governance structures at the Program, Site and School level. This MoU has recently been signed, enabling some implementation barriers to be overcome.

1.3.5. Methodology

Overview

Urbis has collected both primary quantitative and qualitative data for this evaluation, as well as reviewed existing secondary data sources. This data collection process occurred in three waves, as described above. Eight main data sources helped to inform this evaluation, as shown in Table 2 below.

Table 2 – Research data sources

Data Source	Wave 1	Wave 2	Wave 3
Interviews with WHIN Coordinators	n=3 participants	n=3 participants	n=3 participants
Interviews with School Executives and school staff	n=10 participants	n=23 participants	n=21 participants
Interviews and focus groups with health and community service providers	N/A	n=15 participants	n=12 participants
Interviews with parents and family members	N/A	n=1 participant	n=4 participants
Focus groups with young people	N/A	n=17 participants	n=13 participants
Focus group with Ministry stakeholders	N/A	N/A	n=8 participants
Consultation with Department of Education staff	N/A	N/A	n=2 participants
Review of service and education data	✓	✓	✓

Interviews with WHIN Coordinators

Interviews were conducted with the three WHIN Coordinators, either in person or by telephone and video conference. Each interview lasted for up to 90 minutes. Interviews were facilitated by semi-structured discussion guides and transcribed for analysis.

Interviews with School Executives and school staff

Interviews were undertaken with a variety of school staff from Young (n=16), Tumut (n=19), and Cooma (n=18) either in person or by telephone and video conference. This included School Executive members, such as Principals and Deputy Principals, and school staff, including teachers responsible for student wellbeing and school counsellors. Some individuals were interviewed multiple times across the three waves of data collection. Each interview lasted for up to an hour. Interviews were facilitated by semi-structured discussion guides and transcribed for analysis.

Interviews and focus groups with health and community service providers

Interviews and focus groups were conducted with health and community service providers (i.e. mental health clinicians, community development officers, and family support workers) based in Young (n=6), Tumut (n=11) and Cooma (n= 10) either in person or by telephone and video conference. Each interview lasted for up to an hour. Interviews were facilitated by semi-structured discussion guides and transcribed for analysis.

Interview with parents and family members

Interviews were conducted with family members based in Young (n=2), Tumut (n=2) and Cooma (n=1) by telephone. Each interview lasted for around 30 minutes. Interviews were facilitated by semi-structured discussion guides and transcribed for analysis.

Focus groups with young people

Focus groups were held with students 16 years and over in Young (n=9), Tumut (n=9), and Cooma (n=12) in person and by videoconference. Students younger than 16 were excluded in accordance with research

approval from the Greater Western Human Research Ethics Committee and the National Statement on Ethical Conduct in Human Research (2007). Each focus group lasted for up to an hour. Focus groups were facilitated by semi-structured discussion guides and transcribed for analysis.

Focus group with Ministry stakeholders

A focus group was held with stakeholders from the Ministry (n=8) by video conference. The focus group lasted for 90 minutes and was facilitated by a semi-structured discussion guide and transcribed for analysis.

Feedback from Department of Education Staff

Feedback was received from Department of Education staff (n=2) by email or videoconference. Staff were asked to provide their feedback by answering four questions regarding the WHIN Coordinator Model.

Service and Education Data review

WHIN Coordinators were asked to provide deidentified outcome service data for the period 1 March 2018 to 31 July 2020. Urbis provided an Excel template for WHIN Coordinators to collate relevant service data. Data was provided by referrals received for Young (n=238), Tumut (n=157), and Cooma (n=360). Analysis was undertaken to determine:

- the extent of service access
- the demographic profile of service users
- presenting issues facing service users
- the referral pathways provided for service users
- evidence of health outcomes.

The Department of Education provided deidentified attendance and suspension data for a sample of 95 students referred to the WHIN for the period 15 October 2018 to 12 April 2019. The sample included students from Young (n=57), Tumut, (n=12), and Cooma (n=26). Analysis was undertaken to determine evidence of achievement of education outcomes. The Department of Education also provided data on the level of disadvantage experienced by the 11 schools which the WHIN Coordinators primarily supported during the Pilot. Community profiles of each Pilot site are provided in Appendix D.

Analysis was undertaken in Microsoft Excel and reported at the site level.

1.3.6. Presentation of results

Qualitative research

Urbis held an internal workshop to thematically analyse the qualitative data collected through Wave 3 site visits. Interview transcripts were analysed and compared with previous waves of research to identify Pilot-wide and site-specific findings.

Quantitative research

Despite the development of the WHIN Program Management Tool (WPMT) for data collation in June 2019, there was a significant variation in the completeness and consistency of the datasets provided by each WHIN Coordinator. In addition, service data was collected inconsistently in 2018, limiting options for analysis. As such, the dataset used for this service analysis was incomplete. It is estimated that data for at least 83 instances of services are unavailable as they occurred prior to the implementation of the WPMT, or estimations of non-reported instances of service by WHIN Coordinators (approximately 45 from Tumut, 38 from Cooma, and an unknown number from Young). This report only presents analysis for the available data for the period 1 March 2018 – 31 July 2020, which underreports the total instances of service at each site.

Specific program data terminology is defined in the WPMT, and the data dictionary is provided in Appendix D.

2. MODEL IMPLEMENTATION AND GOVERNANCE

This section of the report outlines evaluation findings relating to the implementation of the WHIN Coordinator Model Pilot, based on consultations with WHIN Coordinators, members of the School Executive and staff, community stakeholders, and students. This section also outlines the governance structures that underpin the Pilot. As there is variation in the implementation of the Model across the three Pilot sites (see Section 3 for more detail), the implementation experience reflects a thematic analysis of common experiences.

2.1. IMPLEMENTATION EXPERIENCE

The WHIN Coordinators are being supported to integrate with school systems

Over the last 12 months, it appears the WHIN Coordinators are being supported to integrate with school learning and wellbeing structures. School Executive and staff reported that improved lines of communication and increased attendance at learning and wellbeing team meetings had positively impacted on integration. For example, one School Executive explained that previously the WHIN Coordinator did not regularly attend wellbeing team meetings until the Principal set an expectation that these meetings were important to attend, which improved their engagement and communication with school wellbeing staff. While the School Executive acknowledged a need for continued attendance to reap full benefits, the early signs are positive. In addition, some School Executive and staff reported that, over time, participating in ongoing conversations with the WHIN Coordinators regarding role delineation and referral pathways, increased clarity of role within the school.

> **There was a much greater attendance from [the WHIN Coordinator] at the learning wellbeing meeting…because that was one of the issues that we were sort of having…going back 18 months that certainly wasn't something that was happening so that was all falling into place…we were going yes this is now really functioning in a way that we could actually see success.**
>
> **School Executive**

> **So [the WHIN Coordinator] very much became…an incredibly confident and valuable conduit between that critical wellbeing fine line that fits between Education and trying to support kids outside for their health and wellbeing to allow them to be successfully engaging in their education.**
>
> **School Executive**

Overall, schools with a clearer understanding of the WHIN Coordinator's role, appear to have more successfully embedded the Model in their wellbeing structures. Feedback from other school staff and WHIN Coordinators, suggest that where some school staff continue to lack understanding of the role, the Model appeared to be less integrated into the school's systems, and ultimately less successful. For example, feedback from a range of staff from one school suggested that there was a lack of clarity of the WHIN Coordinator's role and how they should work with school systems to support student wellbeing. This aligned with feedback that the WHIN Coordinator's engagement with the school's wellbeing team was largely informal, resulting in limited transparency of the health and education outcomes achieved for students referred to the WHIN Coordinator.

Engaged school staff championed implementation of the WHIN Coordinator Model

Implementation of the Model appears to have been facilitated by the integration of the health and education systems at individual schools, particularly during the establishment phase. In schools where a member of the School Executive championed the Model among school staff and adjusted school processes to accommodate the WHIN Coordinator's role, implementation tended to be smoother.

In some cases, WHIN Coordinators, school staff, health and community service providers and young people all consistently reported that greater support from School Executive to promote the WHIN Coordinator Model would have assisted implementation. For example, some young people were frustrated about having to seek out information about the service as the school had not made them aware of the available support. The WHIN Coordinators sometimes reported that School Executives were unwilling to champion the role due to a lack of understanding of, and confidence in, their skills and experience. This finding was supported by feedback from the School Executives themselves, and other school staff.

Socialisation of the WHIN Coordinator role was important for staff to become comfortable with role boundaries and expectations

The evidence suggests the implementation of the WHIN Coordinator Model was positively impacted by sufficient time to 'socialise' the role with school staff. School Executive and staff noted some initial apprehension and misunderstanding of the WHIN Coordinator's role; however, understanding has reportedly increased as implementation progressed; positively impacting on the Model's integration into schools.

> **…when we started this position there was a lot of toing and froing, trying to establish where it was going, what it was doing but this is the third year now and it seems to have gotten into a bit of a routine…people know where things are and people…know the expectations…**
>
> **WHIN Coordinator**

For example, the Interim Evaluation Report highlighted that a perceived overlap between the role of the WHIN Coordinator and the School Counselling Service had the potential to create significant implementation challenges. School Executives explained how initially some school counsellors were apprehensive about the WHIN Coordinator's role and that confusion regarding responsibilities of school counsellors, and the WHIN Coordinator had led, in some cases, to duplication of work. As one School Executive noted: *"the biggest challenge with the WHIN [Coordinator] role was trying to get it to work with the school counselling service."* At many schools, as the WHIN Coordinator spent time learning the school's processes, building relationships with school staff, and demonstrating success in their role, school counsellors have increased their understanding of the WHIN Coordinator's role, and genuinely acknowledge, and sometimes champion its value. In most cases, the WHIN Coordinators are now recognised as a valuable resource, with extensive knowledge of the health system and a respected source of health information for students, school counsellors and other wellbeing staff.

Schools adjusted their wellbeing systems to accommodate the WHIN Coordinator role

In the past year, some schools have made changes to their student wellbeing systems to better accommodate the WHIN Coordinator. School Executive and staff specifically noted they have or were in the process of, improving referral pathways and the allocation of roles and responsibilities in their school wellbeing teams to integrate the WHIN Coordinator role. For example, one School Executive had developed formal guidelines for when and how students would be allocated to the WHIN Coordinator, school chaplain, and school counsellor, or other staff for support. These changes have reportedly reduced role duplication and ensured the WHIN Coordinator was being utilised effectively – this feedback came from the WHIN Coordinators, as well as school staff and executives.

> **This is where things are frustrating, I don't know who [the WHIN Coordinator] sees, when I should get involved…we are restructuring the referral system within the school and also will ask how everyone in the [wellbeing team] sits in their structure.**
>
> **School staff**

> **We have started…regular meetings and then they started again in the last week or so that's been a really good forum to bring up things and I'll bring up communication about telling all the services what I can and can't do…**
>
> **WHIN Coordinator**

School Executive and WHIN Coordinators also reported improved communication processes between WHIN Coordinators and school staff when regular meeting times with School Executive and wellbeing staff were established. One WHIN Coordinator noted that holding regular meetings allowed any issues to be raised (and ideally resolved) and provided the WHIN with an opportunity to update school staff on a student's progress with health and social services. School Executives agreed that establishing regular meetings was useful to identify solutions to issues, as well as to remain informed about student engagement with local services.

If regular meetings did not occur, communication issues between the WHIN Coordinator and school staff and Executive were identified. One School Executive noted that, at times, they were unaware of the services and support students were accessing through the WHIN Coordinator. They also expressed a desire for more frequent communication regarding student progress. This was particularly apparent during the COVID-19 pandemic lockdown when most students were not attending school.

Implementation improved as WHIN Coordinators learnt school-specific systems

School Executive and WHIN Coordinators acknowledged that an understanding of both education and health systems was an important requirement for the successful implementation of the WHIN Coordinator Model. To be effective within a school site, WHIN Coordinators require a strong understanding of student wellbeing policy, school wellbeing structures, existing wellbeing support provided by the Department of Education, and appropriate points of contact to provide information about student progress. School stakeholders reflected that, understandably, the health and education systems had different approaches to managing wellbeing. While health practitioners focus on the health of a client, within the education system, staff must also balance a focus on student education and learning outcomes. This means that school staff sometimes have different requirements and constraints than the WHIN Coordinators when responding to student wellbeing needs, potentially leading to differences in the preferred approach. For example, a teacher may respond to poor student behaviour by removing them from the classroom to maintain a positive learning environment for other students. However, a WHIN Coordinator might be able to identify other causes of poor behaviour, such as side effects from not taking medication with food, which can be more easily addressed.

> **… they have to be able to be education focused, I know they're not educators but they have to be able to be education focused because [the WHIN Coordinator's]…biggest strength is that…we can always bring the conversation back to what's best for the child for their education. I think you potentially create tension between the school and the role if the focus couldn't always come back to education being a priority with this role.**
>
> **School Executive**

Implementation appeared to be more successful where WHIN Coordinators had a greater understanding of education and school-specific student wellbeing policies, as well as the day-to-day operations of schools. As discussed previously, 'socialising' the Model within schools can be a crucial first step in the WHIN Coordinators familiarising themselves with school systems and processes, with this knowledge increasing over time. One WHIN Coordinator explained, *"I've got a greater understanding of what supports are available within Education…and a greater awareness of what hoops school have to jump through, how they work."*

WHIN Coordinators and School Executive agreed that comprehensive orientation to the NSW Education System and individual school systems would have expedited the WHIN Coordinators' understanding of school systems. One school staff member provided the example of another external service operating within the school; reflecting that this organisation had invested in providing their staff with a comprehensive orientation to the education system, and clearly articulating how the service integrated with existing school systems. This reportedly meant the service was better able to integrate with school systems and processes seamlessly.

The impact of the COVID-19 pandemic affected the effectiveness of WHIN Coordinators

The impact of the COVID-19 pandemic was felt to varying degrees across the three Pilot sites. In some instances, the pandemic contributed to communication breakdowns between school staff and the WHIN Coordinators. In others, the closure of external services affected Coordinator's ability to connect students with support. School Executive and staff further reported that restrictions prohibiting school attendance had sometimes disrupted communications between the WHIN Coordinators and school staff. School Executive suggested the lack of face-to-face, incidental interaction had, for example, contributed to the WHIN Coordinators being unable to communicate updates on student progress (or otherwise) to School Executive and staff.

The closure of local services during the COVID-19 pandemic lockdown was an additional challenge; specifically, it was difficult for students and families to maintain engagement with services during this period. In response, school stakeholders noted that the WHIN Coordinators proactively organised teleconferences to ensure continuity of care. This was mostly successful, but some connectivity issues and reduced engagement without face-to-face contact were noted. For example, one community stakeholder appreciated that the Coordinator organised teleconferences to facilitate students' access to drug and alcohol support. Despite this, they noticed students were more likely to get distracted during sessions, and connectivity issues would sometimes cause sessions to be disconnected or end prematurely.

2.2. GOVERNANCE MODEL

The WHIN Coordinator Model functions under a multi-layered governance model, spanning whole-of-Pilot, site, and school levels. Table 3 below summarises the current governance structures. This model was developed using feedback obtained during stakeholder consultations, as well as Model documentation. Findings related to the implementation of the Governance Model are discussed below.

Table 3 – WHIN Coordinator Model Governance Model

GOVERNANCE LAYER	EXISTING STRUCTURE
Whole-of-Model *Responsible for overall Pilot management, interdepartmental coordination and evaluation.*	▪ Steering Committee convened and led by the NSW Ministry of Health. This Committee was originally formed to oversee the Pilot evaluation but has since adopted a broader Pilot governance role to oversee the implementation and evaluation of the WHIN Coordinator Pilot. The Steering Committee comprises of stakeholders from the Ministry of Health, Local Health Districts, and the Department of Education. ▪ Memorandum of Understanding between NSW Health and the NSW Department of Education, which includes Operational Guidelines.
Site Governance *Responsible for the intra-school coordination of the WHIN Coordinator Model at each Pilot site*	▪ Local governance committee including Principals of participating schools, Department of Education Director of Educational Leadership, the WHIN Coordinator, and the WHIN Coordinator's line manager. The network coordinates how the WHIN Coordinator functions across multiple schools at the site. ▪ LHDs provide operational management and clinical supervision to WHIN Coordinators and guide Model implementation. These staff members have had increasing involvement in site or school level governance over the course of the Pilot.
School Governance *Responsible for integration of the WHIN Coordinator with existing school wellbeing systems*	▪ Managed through existing school leadership structures, usually by the member of the School Executive responsible for student wellbeing (i.e. Principal, Deputy Principal, or head teacher wellbeing). The strength of school-level governance depends on the school leadership and appears to have increasingly involved NSW Health over the course of the Pilot.

The implementation of the Model pilot is a collaboration between the Ministry and the Department of Education. At a whole-of-Model level, governance is led by the Ministry through the Steering Committee with representation from the Ministry, the Department of Education, relevant Local Health Districts and Regional Department of Education representatives. At the site level, governance is managed by Local Governance Committee, with representation from the host school (typically a high school), other schools involved with the Pilot, and the LHD.

Consultations suggested that consistent representation of appropriate stakeholders at each governance level may support interdepartmental collaboration, particularly as the need for governance consistency may increase as the Model is expanded. To ensure a stronger and more consistent approach to governance does not come at the expense of flexibility in service delivery to meet local needs, strengthening governance consistency should concentrate on three areas:

- consistency of representation, so that appropriately senior stakeholders from both the Department of Education and NSW Health are involved and engaged at the whole-of-Model, site, and school levels. Of particular importance is that the representatives at each governance layer have the authority to adjust policies and processes as necessary to facilitate successful interdepartmental collaboration
- clear lines of accountability, to ensure that all management roles and responsibilities are understood and visible to key stakeholders

- defined resolution processes, to allow for any issues, concerns or disagreements to be identified and appropriately settled.

Inconsistent Steering Committee representation hindered adjustments to Model design and implementation

Feedback from stakeholders identified a high turnover in Steering Committee membership, particularly representation from the Department of Education. This reportedly meant that the Steering Committee sometimes lacked a consistent understanding of the Pilot amongst its members. It also made it difficult to efficiently identify and implement improvements to the Model design or the implementation process. Ministry and LHD stakeholders reflected that this has been particularly challenging when adjustments to policy were required to successfully embed and integrate the WHIN Coordinators within schools.

Site-level interdepartmental partnerships were strengthened, but some governance process could be improved.

Feedback from WHIN Coordinators highlighted that site-level governance meetings were useful for supporting the implementation and consistent understanding of the Model. The WHIN Coordinators especially appreciated the way in which these meetings encouraged communication and collaboration between the LHDs and the Department of Education, which they believed "reinforced the partnership" between health and education stakeholders.

WHIN Coordinators explained that having representatives from LHDs and the Department at these meetings provided opportunities for open discussion of Model implementation and identification of possible solutions. In one instance, a WHIN Coordinator explained that the scope of their role required clarification with School Executives and staff, and their LHD manager was able to articulate and reinforce their role scope at these meetings. This clarification helped ensure that all stakeholders had a shared and consistent understanding of the WHIN Coordinator's role and responsibilities. In another instance, it was agreed by the Local Governance Committee that a WHIN Coordinator's role is reduced from supporting six schools to two schools, in response to implementation challenges the site was experiencing.

While these examples demonstrate the value of site-level governance to manage implementation, feedback further suggests that key stakeholders are still not always involved in crucial decision-making. For example, some Principals were not made aware when their school was removed from the Pilot. This suggests that some of the decision-making and communication processes of site-level governance may need to be clarified or improved to ensure consistency and better support implementation.

Lines of accountability within schools became clearer

Feedback from WHIN Coordinators and School Executive highlighted that governance structures within schools have become stronger over the last 12 months. School Executives attributed this to their better understanding of the WHIN Coordinator Model. Most School Executives understood their role as responsible for integrating their WHIN Coordinator within the school wellbeing structure and for managing school-level implementation challenges, but not as responsible for supervising the WHIN Coordinator. WHIN Coordinators shared this understanding, noting increased confidence with lines of accountability, such as which issues to report to a School Executive and when to speak with their LHD manager. Consistent with the integration of the WHIN Coordinator within a school, the evidence suggests that lines of accountability were clearest in schools where the WHIN Coordinator Model was well embedded within school wellbeing structures (as discussed in Section 2.1).

I guess my role at the school is to make sure that she is embedded into our school procedures and processes and so I guess in that side of things yes there is that level of governance and accountability, I do tell her what we'd like from her but yeah not as a direct line supervisor.

School Executive

There still appears to be a need for greater transparency with School Executives for employment-related matters. For example, some School Executives explained that their WHIN Coordinator had, at times, taken extended leave without their knowledge, contributing to a breakdown in care for students. This suggests a need for clearer communication between health and education staff, particularly in circumstances where it may impact service delivery.

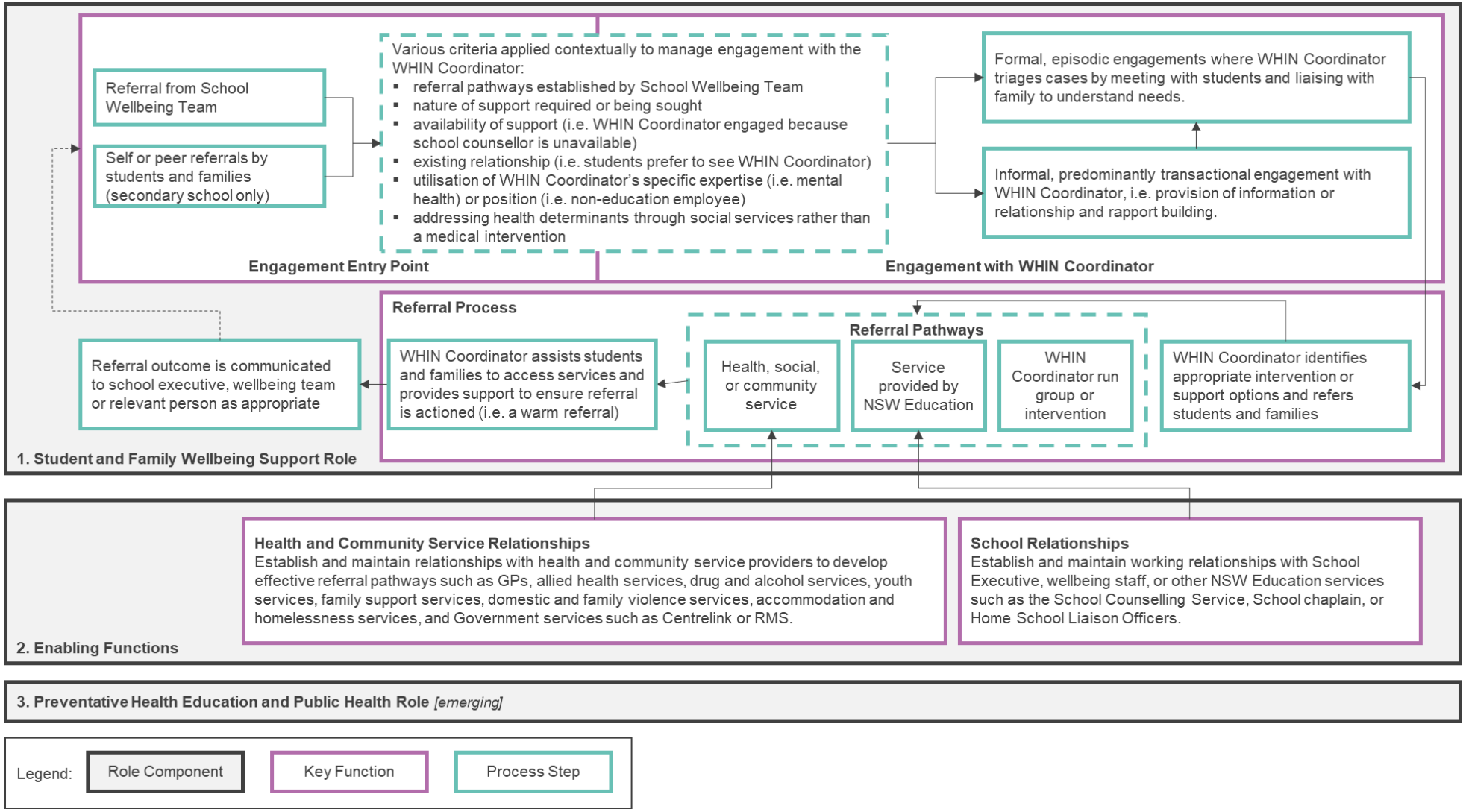
3. SERVICE ACCESS AND EXPERIENCE

This section of the report outlines referral pathways for the WHIN Coordinators and the type of support provided to students and families. This is based on consultations with WHIN Coordinators, members of the School Executive and school staff, health and community providers, parents and students. As there is variation in implementation of the Model across the three Pilot sites, the service access experience reflects a thematic analysis of common experiences. This section of the report also draws upon service data to outline evidence of Model reach.

3.1. SERVICE DELIVERY MODEL

The WHIN Coordinator Model provides health and wellbeing support by connecting students and parents with health and community services. Figure 1 overleaf shows the Service Delivery Model as it currently operates across the three pilot sites.

Figure 1 – WHIN Coordinator Service Delivery Model



3.1.1. Local variations to service delivery model implementation

The implementation of the Service Delivery Model varies between each Pilot site. Feedback from stakeholders suggests that implementation of the WHIN Coordinator is influenced by a variety of factors, including the professional background and experience of the WHIN Coordinator, the school context and environment, existing health and social support structures and their level of engagement with schools, and geography. Notable variations include:

- Practices in Young and Cooma, which allow for informal engagement and rapport building between students and the WHIN Coordinator before a formal referral or self-referral is made. In Young this occurs through the WHIN Coordinator's role as the "face" of Care Connect, Young High School's student wellbeing hub. Students can access Care Connect without a referral, and some students will regularly drop-in, which provides the WHIN Coordinator with an opportunity to check-in with them and build rapport. In Cooma, the WHIN Coordinator frequently spends time on the playground at Monaro High School during lunchtime. This provides students with an opportunity to become familiar with the WHIN Coordinator and approach her for informal advice.
- Locating the Cooma WHIN Coordinator on a primary school campus. This allows the WHIN Coordinator to spend time informally engaging with parents and family members during school drop-off and pick-up. This provides opportunities for families of primary school students to make self-referrals to the service.
- Limiting the WHIN Coordinator's scope of practice at Tumut High School to focus on providing support to families of vulnerable students. This means that students are unable to self-refer to the WHIN Coordinator and the WHIN Coordinator's role within in the School Wellbeing Team is mostly contained to supporting family members, rather than students. This variation may account for lower instances of service in comparison with the other Pilot sites.
- The WHIN Coordinator in Tumut provides outreach support to Tumbarumba, which is a one-hour drive from Tumut. This limits the WHIN Coordinator's flexibility as they have increased travel requirements.

3.1.2. Student experience of the service

Feedback from students highlighted key features of the WHIN Coordinator Model, and the WHIN Coordinators themselves, which they appreciated. They suggested that students valued the service because it is:

Confidential	"They don't have to let their parents know."
Convenient	"It's at school. They come to the school."
Familiar	"It's like a face they know- instead of not talking or knowing anyone, not knowing what to do, what their role is."
Private	"I remember like the counselling used to be on the clock and if the appointments were running late you'd stand outside it and people would look at you whereas in here, the window is sort of frosted so you can't see in."
Non-stigmatising	"A positive, friendly environment, like anyone can come here and not be judged and no stigma surrounding anything that they have to ask about really and be alright."
Informal	"They're not wearing a suit or tie." "You can just come in and organise it yourself."
Non intimidating	"They don't have a big scary title." "If they have a title, it's like you're a bit different to everyone else. You have to go and see a special person because you're special." "I think also like sometimes if you've got a minor issue and someone has a big fancy title you'd be like oh no I don't want to go see them. Yeah I don't want to go that far."
Welcoming	"It's bright and feels welcoming."
Positive	"They greet you with a smile."
Knowledgeable	"They might fill out a form for the doctor. I don't know how to do this and neither do my parents. I'll come up here and see if anyone knows about it."
Helpful	"Definitely for me it's opened my eyes to like a broader range of like health stuff not just oh they're like going to the counsellor for mental health, It's like there's a specific set of things they can do here." "It's just that first stepping stone leads off to different pathways to really get the understanding of how everything works and where you can kind of get help."

These comments suggest that the WHIN Coordinator Model offers students a pathway to health and wellbeing support that they would otherwise not easily be able to access.

3.2. SERVICE ACCESS

Students predominately accessed the WHIN Coordinator through a referral from the school's health and wellbeing team. In some cases, students referred their peers directly to the WHIN Coordinator, or the Coordinator informally identified students requiring support. The various service access experiences are explored in further detail below.

Students accessed WHIN Coordinators through school wellbeing structures

Most students access WHIN Coordinators through a school's wellbeing structures, either formally via a referral from the wellbeing team or informally at the suggestions of a Principal, teacher, or year advisor. In some cases, the wellbeing team and WHIN Coordinators met to discuss students who may benefit from the support of the WHIN Coordinators. This involved discussing issues regarding a student's behaviour, health, mental health and/or family issues.

In other cases, students were informally referred to WHIN Coordinators through suggestions made by Principals, teachers, and year advisors. The WHIN Coordinator then triaged cases by meeting with students and their families to understand health and wellbeing needs further. One School Executive noted that referrals made by Principals and Deputy Principals tend to be for students with more complex needs that were beyond the scope of the school wellbeing system to support.

> **… [the WHIN Coordinator] will take referrals from the Learning Support Team which involves…members of the wellbeing team. [They] will work with the counsellors where counsellors see the need and [they] more often than not get a fairly significant amount of [their] referrals directly from [the Principal] or from the Deputy Principal …the pointy end wellbeing needs will often present through the Principal or the Deputy…**
>
> **WHIN Coordinator**

Self and peer referrals by students also facilitated access to WHIN Coordinators

Self and peer referrals also appear to have been an additional pathway to accessing the WHIN Coordinators, with the service data revealing 102 self-referrals were made. In some cases, school stakeholders described students self-referring by attending the WHIN Coordinator's office and requesting their support.

In one school, students commonly reported referring peers to the WHIN Coordinator. This tended to occur when students found the WHIN Coordinator's support valuable and believed their peers would benefit from similar support. For example, one WHIN Coordinator explained how they supported a student to obtain a Medicare card or access a GP, and the student would refer their friends for similar support.

> **…there's a definite increase in peer referrals so students kind of coming along with a peer who may have engaged with a service before… I've definitely got some students that have been coming along with their friends saying 'look you did these things for me can you please help my friend do that too'…**
>
> **WHIN Coordinator**

WHIN Coordinators informally identified students and families' needs

Evidence suggests that some WHIN Coordinators informally monitor students and families to identify early signs of health and wellbeing needs. According to WHIN Coordinators, school staff, and community stakeholders, WHIN Coordinators would identify emerging issues through observing students and their peers in the school environment, including at lunchtimes and in the school playground. For example, young people spoke of their WHIN Coordinator, noticing when a student looked consistently "sad" at lunchtimes and followed up accordingly.

School stakeholders noted that following identification of a potential issue, that the WHIN Coordinator would typically conduct an informal assessment of student and families' needs. This process included relationship and rapport building to 'softly' engage with students or parents. School staff, community stakeholders and young people, noted that in some instances, the WHIN Coordinator would check-in with students when seeing them on school grounds or have short conversations with parents before or after school. In other cases, WHIN Coordinators provide students with snacks and hot drinks to build their trust and open a conversation.

> **[The WHIN Coordinator] doesn't sit in [their] office, very rarely in the office. [They're] out with kids, [their] lunchtime is spent out in the playground with kids and [they're] talking with them and doing those check ins which I think is so valuable…**
>
> **School Executive**

Another feature of the Coordinator's early-intervention approach involves the provision of information and guidance on health and wellbeing. School staff, community stakeholders and WHIN Coordinators explained how a WHIN Coordinator can provide general advice about peer relationships, anger management strategies and information on sexual health, contraception, and puberty. They were also noted as offering information about available support services. For example, young people spoke of the WHIN Coordinator, distributing contact details for mental health services in the community. This provided another avenue for WHIN Coordinators to open conversations with students about their health and wellbeing.

3.3. SERVICE REACH

Service data suggest the Model is reaching the target cohort at all three Pilot sites and is successfully referring students and families to health and community support services. The analysis below presents the extent of service access, the demographic profile of service users, presenting issues facing service users and the referral pathways provided for service users. While the WPMT for collating data was provided, there was a significant variation in the completeness of the datasets. Data limitations are outlined below, and this analysis likely underreports the total instances of service at each site. Specific program data terminology is defined in the WPMT, and the data dictionary is provided in Appendix D.

3.3.1. Reach overview

Data from the three Pilot sites indicate that the Model reached nearly 800 students from a total of 17 schools over the pilot from 1 March 2018 to 31 July 2020. A total of 789 instances of service were recorded during the Pilot, with more than half for high school students (58%) and over one third (36%) were primary school services, with a small number of clients no longer attending school. About four in five referrals to the Model came from school staff (78%), including teachers, health and wellbeing staff and non-teaching school staff. A smaller number of clients, self-referred (17%) or were referred by parents (15%). On average, students saw the WHIN Coordinator on four occasions, with two-thirds of cases resolved within two months.

Across the three Pilot sites, mental health was the most common presenting issue (246 instances), followed by social support (222 instances) and behavioural symptoms (126 instances). This indicates a wide range of students with varying complexities of need have been supported across the whole trial, and that cohorts are requiring different types of assistance based on their location.

Overall, consultations revealed that WHIN Coordinators often provide support to students and families with complex needs. This sometimes includes cases which are particularly difficult to manage due to the involvement of multiple government agencies, or the nature of the issue a student or family is experiencing. Feedback from WHIN Coordinators and School Executives at all sites provided examples highlighting the level of complexity of some case, including supporting students:

- following the suicide of close family members or friends
- who were involved in cases of incest
- who were victims of sexual assault and rape.

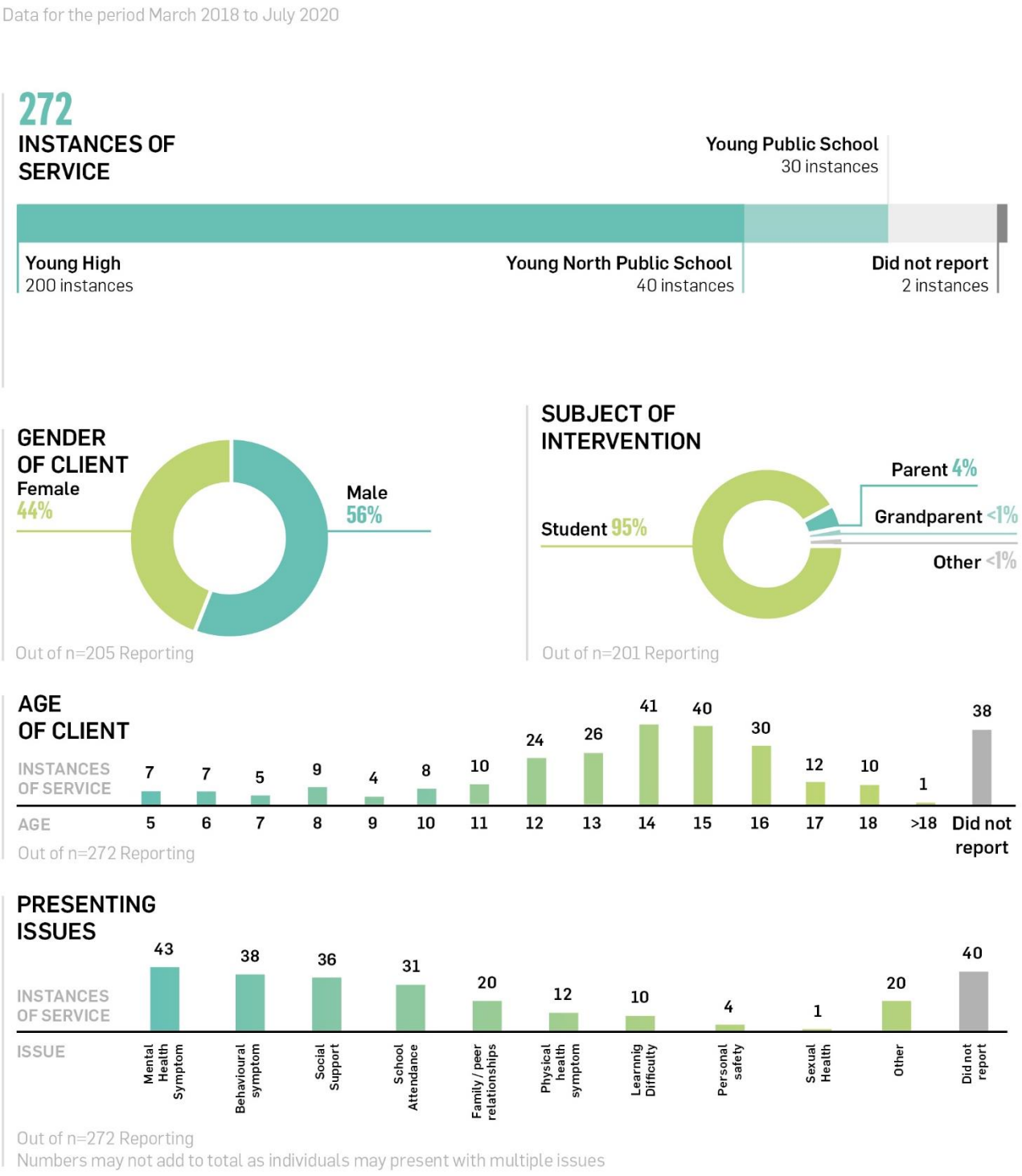
While it was acknowledged that the WHIN Coordinators were not solely responsible for responding to these complex cases, they were often a student's most 'trusted adult' and had a significant role coordinating their support.

While there was a reasonable level of consistency between the three Pilot sites, some key differences in service data can be observed. In Young there was a greater proportion of male clients (56%) compared with Tumut (48%) and Cooma (40%). Interestingly, this trend correlates with the gender of the WHIN Coordinator, which may suggest that students prefer to engage with somebody of the same gender. The WHIN

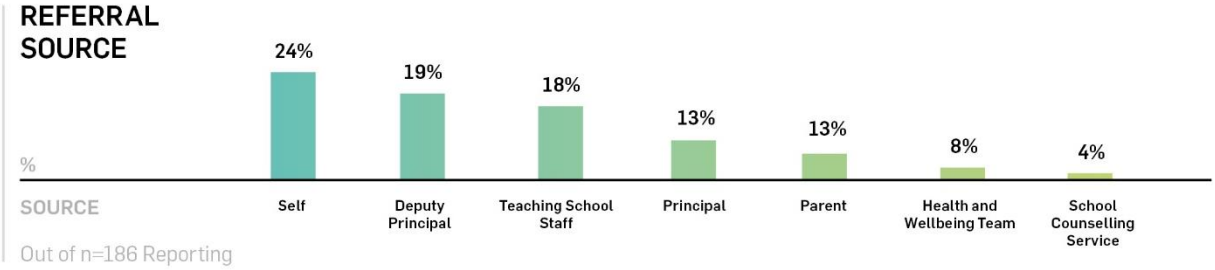
Coordinator in Cooma has supported a greater proportion of primary school clients (40%), compared with Young (25%) and Tumut (20%). This suggests that the Model has been more successfully integrated with primary schools in Cooma, which may be due to the WHIN Coordinator's office being located on a primary school campus. Finally, the primary referral source at each site varied, highlighting differences in how the Model has been implemented. In Young, 25% of clients referred themselves to the WHIN Coordinator, which may highlight the role of the Care Connect centre in allowing students to access health and wellbeing support. The Care Connect Centre is a wellbeing hub where school and social support services from the community co-locate to improve engagement with students and families. In Tumut, 30% of referrals came through the Health and Wellbeing team, which was the established referral pathway for Tumut High School. In Cooma, 39% of referrals came directly through the Principal, which might suggest a less structured approach to integrating the Model within schools.

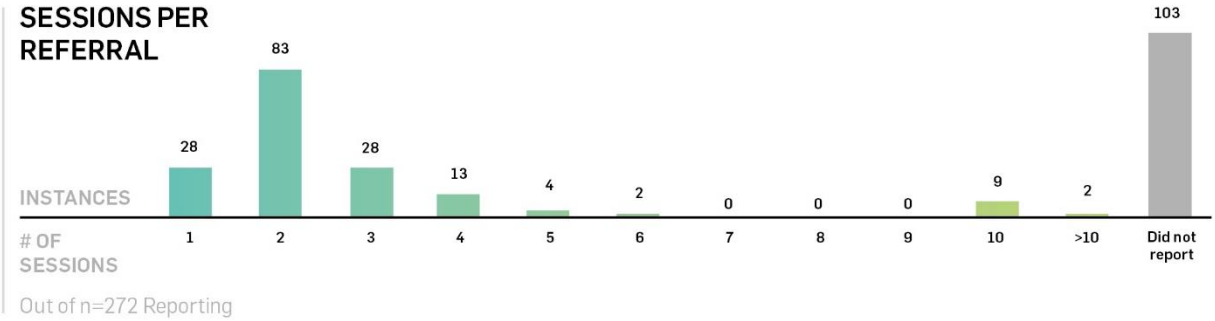
3.3.2. WHIN service data – Young

Figure 2 – WHIN Service Data – Young



Data for the period March 2018 to July 2020





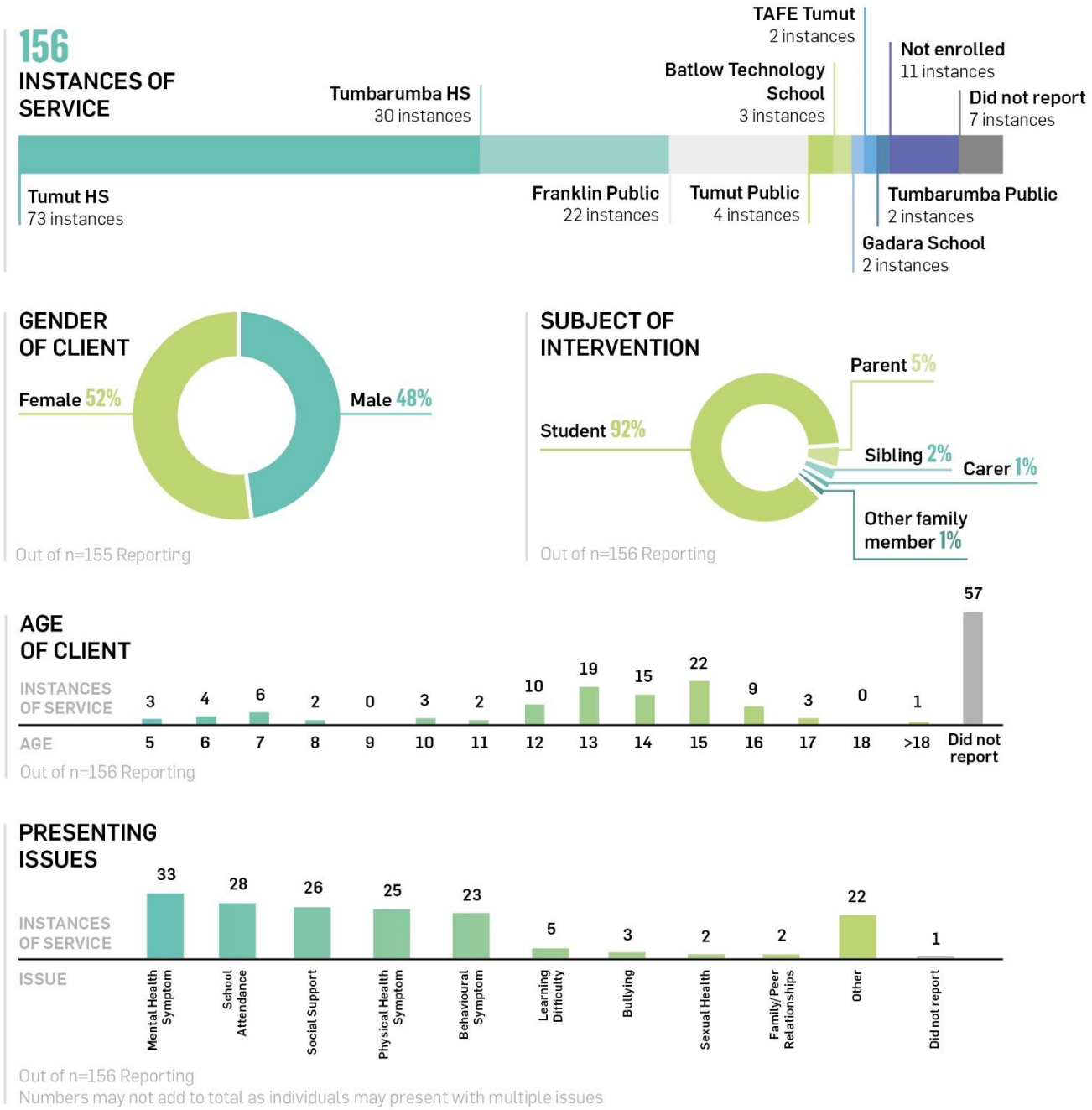
Notes and clarifications

- An ‘instance of service’ counts the number of unique referrals accepted by the WHIN Coordinator. This may be different to the number of unique individuals who have accessed the WHIN Coordinator, and different to the total number of occasions which a WHIN Coordinator interacted with clients.
- This report only presents analysis for the available data for the period 1 March 2018 – 31 July 2020. Due to inconsistent and incomplete data collection, the total instances of service may be underreported.
- The high frequency of ‘did not report’ responses for ‘client age’, ‘presenting issue’, and ‘sessions per referral’ is due to incomplete data collection.

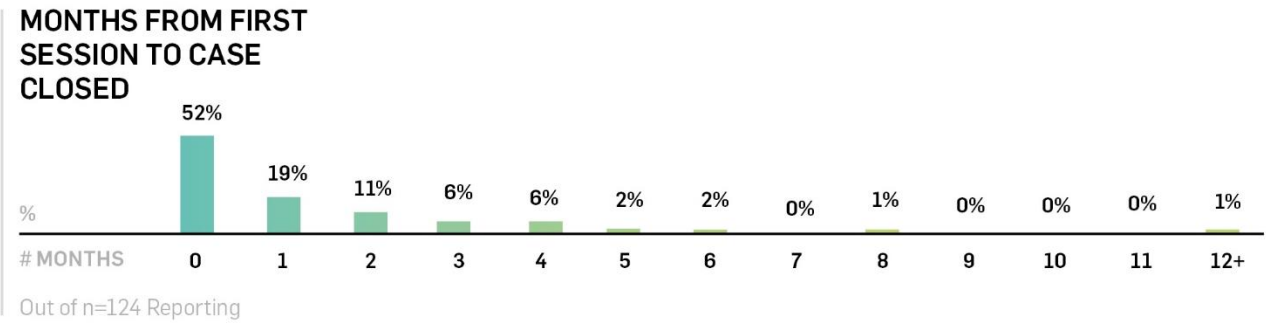
3.3.3. WHIN service data - Tumut

Figure 3 – WHIN Service Data – Tumut

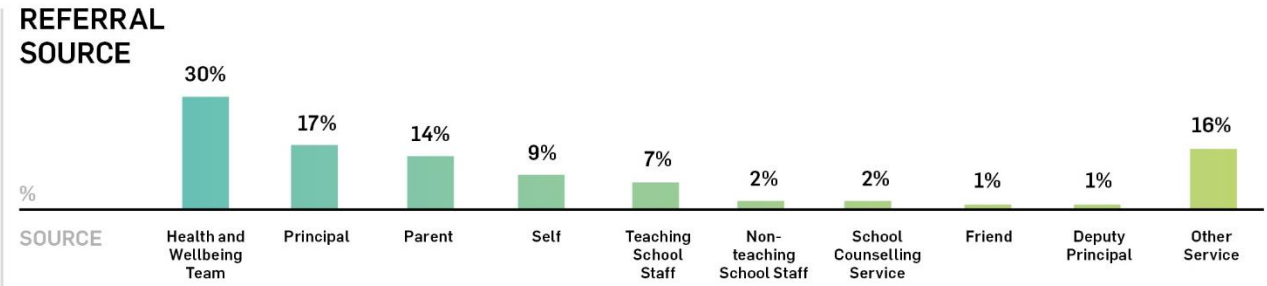
Data for the period March 2018 to July 2020



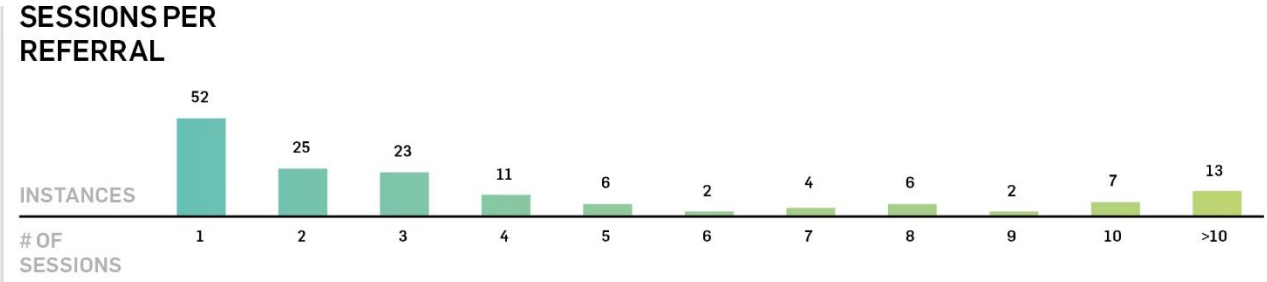
Data for the period March 2018 to July 2020



Out of n=124 Reporting



For n=155 Referrals
Numbers may not add to total as individuals may present with multiple issues



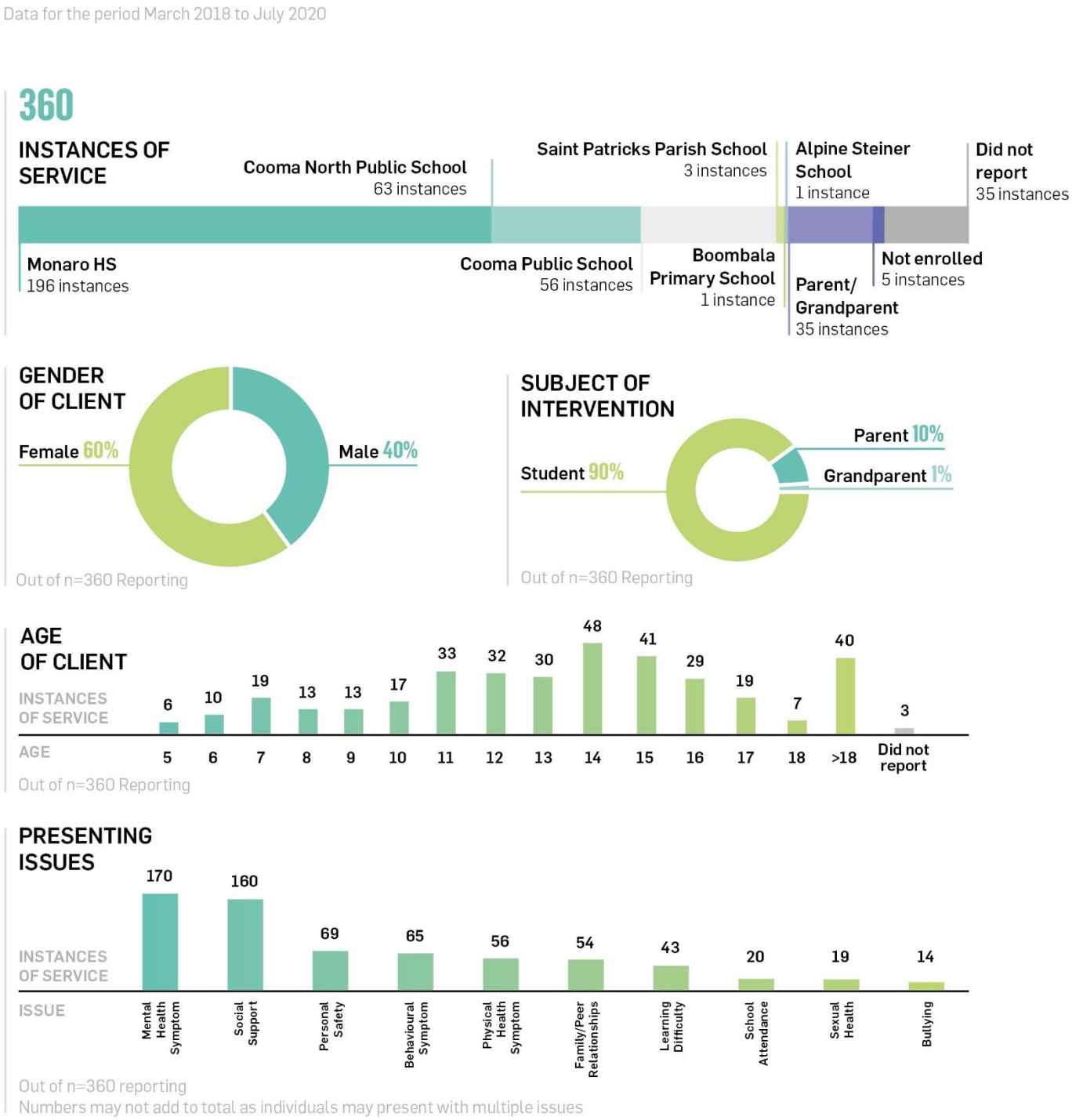
Out of n=151 Reporting

Notes and clarifications

- An ‘instance of service’ counts the number of unique referrals accepted by the WHIN Coordinator. This may be different to the number of unique individuals who have accessed the WHIN Coordinator, and different to the total number of occasions which a WHIN Coordinator interacted with clients.
- This report only presents analysis for the available data for the period 1 March 2018 – 31 July 2020. Due to inconsistent and incomplete data collection, the total instances of service may be underreported.
- More structured referral pathways at Tumut High School may account for lower instances of service in Tumut compared with other Pilot sites.
- The high frequency of ‘did not report’ responses for ‘client age’ is due to incomplete data collection.
- The high frequency of ‘other’ responses for ‘presenting issue’ is due to the inclusion of 10 students who entered the service through participation in a group activity.

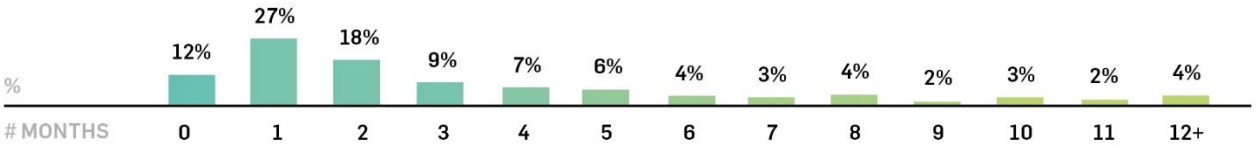
3.3.4. WHIN service data - Cooma

Figure 4 – WHIN Service Data – Cooma



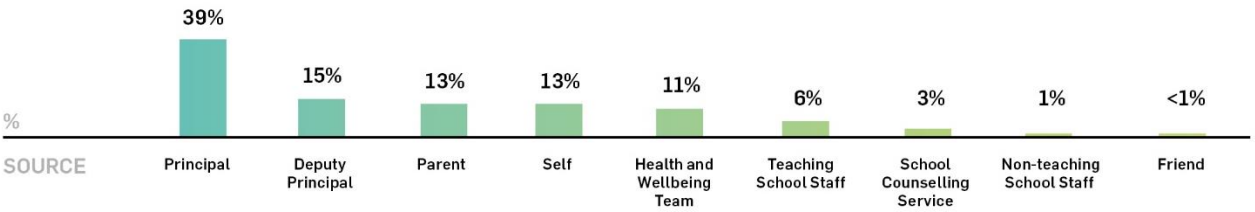
Data for the period March 2018 to July 2020

MONTHS FROM FIRST SESSION TO CASE CLOSED



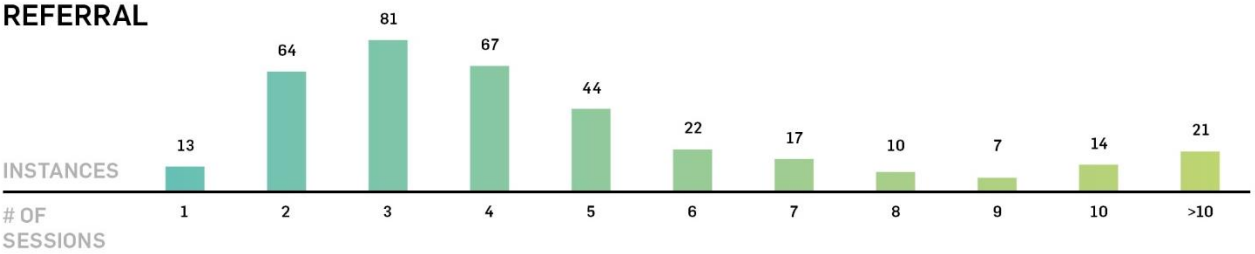
Out of n=309 Reporting

REFERRAL SOURCE



For n=360 Referrals
Numbers may not add to total as individuals may present with multiple issues

SESSIONS PER REFERRAL



Out of n=360 Reporting

Notes and clarifications

- An 'instance of service' counts the number of unique referrals accepted by the WHIN Coordinator. This may be different to the number of unique individuals who have accessed the WHIN Coordinator, and different to the total number of occasions which a WHIN Coordinator interacted with clients.
- This report only presents analysis for the available data for the period 1 March 2018 – 31 July 2020. Due to inconsistent and incomplete data collection, the total instances of service may be underreported.

3.4. PROVISION OF SUPPORT

WHIN Coordinators provide a range of support to students and families, including navigation of service systems, facilitating continuity of care, connecting school and community service systems, providing health promotion information, and addressing barriers to care. These various support experiences are explored in further detail below.

WHIN Coordinators supported students and families to navigate the health and social service system

The evidence strongly suggests that WHIN Coordinators supported students and families to navigate the health and social service system. School and community stakeholders agreed that accessing health and social services can be difficult, particularly for vulnerable students and families, or for those with complex needs. These students and families often have limited knowledge of available services and how to access them. They can also lack the health literacy to understand health information such as medical prescriptions or appointment scheduling. Absence of transport was noted as an additional barrier to navigating the service system.

WHIN Coordinators were able to support students and families overcome these challenges by assisting with service navigation, identifying appropriate service options, and managing referrals. The WHIN Coordinators were able to assess students' needs and refer them to relevant internal (i.e. school services or supports) and external (i.e. community or primary health care) services. The WHIN Coordinators also appear to have assisted with service intake processes including the provision of information about the student and their family. This involved WHIN Coordinators providing services with information regarding health, mental health and behavioural issues, family, and service engagement history, or supporting students and families to complete paperwork.

> **… we have a kindergarten child with an intellectual disability…who is waiting to see a cardiac specialist and the family are a vulnerable family, but you know they desperately want to make sure that their child is getting the care that they need, and they were unable to navigate when the appointment was and seemed to be confused and unable to find out from the clinic… when it was…so [the WHIN Coordinator] just facilitated that…**
>
> **School Executive**

> **… a child in Year 1 that is clearly ADHD with a single mum with no transport, no money, how do you get those people to a paediatrician so [the WHIN Coordinator] provides that service whereby [they] can support the parents, [they] can talk to the healthcare professionals…assist with transportation support…**
>
> **School Executive**

Service access was further facilitated by WHIN Coordinators transporting students to appointments. This increased students' ability to access services and reduced the time spent away from school. This support was particularly valued by students with parents who could not provide transport. For example, one School Executive spoke of a parent not being able to take their child to paediatric appointments as they did not have access to a car or money for transport. The WHIN Coordinator supported their access to paediatric services by driving them to appointments, as well as by liaising with the paediatrician to ensure they received the appropriate support.

Feedback from school and community stakeholders also revealed that WHIN Coordinators support students and families to navigate the service system by making health information more relatable and easier to understand. This included explaining health and wellbeing in simple language and in ways that relate to their personal experiences. This was highlighted as being particularly useful for vulnerable families, such as those with low levels of literacy.

For example, one School Executive recounted the story of a kindergarten student from a vulnerable family who was waiting to see a cardiac specialist. Through the enrolment process, the School Executive identified that this family had limited health literacy and were seemingly overwhelmed and confused with how to navigate the service system to ensure their child received appropriate services and support. The School Executive then referred the family to the WHIN Coordinator, who was able to support the family navigate the health care system. With the Coordinator's support, the family were able to schedule and attend an appointment for the student to see the cardiac specialist.

Ongoing check-ins with students, families and services facilitated continuity of care

It appears that WHIN Coordinators are often the only professional involved in a student and family's experience across the school and the health and social service system. The WHIN Coordinators are uniquely positioned to connect services with timely, comprehensive information about a student's care and needs. WHIN Coordinators were reported as having oversight of students over time, enabling them to stay informed of student progress or setbacks with services, and any contributing factors such as family issues. They were noted as using this information to keep all service providers involved in the care of the student (i.e. school wellbeing and executive staff, health services and parents) updated to ensure the provision of effective treatment and follow-up care.

For instance, a health service provider reported that due to the COVID-19 pandemic, they have only been able to undertake 30-minute videoconferences with students requiring drug and alcohol support. This service required the local WHIN Coordinator to support engagement during the sessions, and a debrief thereafter. The WHIN Coordinator was highlighted as working collaboratively with the service to ensure students attended their sessions, had a debrief, scheduled follow-up appointments (where necessary), and provided ongoing updates regarding student progress. It was suggested that this collaboration supported students to receive ongoing care, and without the WHIN Coordinator, students may have disengaged with the service.

It was also reported that the WHIN Coordinators assisted students and families to continue engaging with services. In some cases, students and families were reported as disengaging in care due to general setbacks, family issues or the impacts of the COVID-19 pandemic. The local WHIN Coordinator supported students and families to re-engage in care by emphasising the value of care, scheduling ongoing appointments, and checking-in with services to ensure students and families attended appointments. This hands-on assistance was found to support students and families to continue with care and treatment, enabling continuity of care.

WHIN Coordinators provided a conduit between the school wellbeing system and local health and community service system

There is strong evidence that indicates WHIN Coordinators have strengthened the relationship between a school's wellbeing team and local health and community services. WHIN Coordinators were recognised for connecting schools to health and community services through sharing information and building relationships with key stakeholders. Without breaching confidentiality, the WHIN Coordinators collected and shared information regarding students' family context, education history, and health and wellbeing issues, with relevant school and health and community service providers. School Executive and staff explained that this information sharing was facilitated through consistent communications between the WHIN Coordinator and School Executive and wellbeing staff, to provide updates on what support students received. This information allowed both systems to adjust their support to ensure it remained relevant to student needs. Health and community service providers explained that without updates from the WHIN Coordinator, they would have been unaware of much of this information and service provision for students would have been disjointed.

> **… I think that's super important, maintaining relationships with GPs…connecting with a dietitian, connecting with a physio…it's just really great to keep those connections going because when school is struggling with a child you already have the relationship so you can go look I'm going to my friend the speech pathologist…**
>
> **WHIN Coordinator**

Feedback from school and health and community service providers also revealed that WHIN Coordinators built strong relationships to further connect schools and the local health and community service systems. The WHIN Coordinators were recognised by school staff and health and community service providers for their extensive knowledge of the local service system, which supported them to build strong relationships and initiate appropriate referrals to these services. School Executive and staff also acknowledged WHIN Coordinators for building relationships with school wellbeing services (e.g. school counsellors). This reportedly allowed school services to better understand the WHIN Coordinator's role and the local health service system, encouraging more referrals to be made to these services.

Health promotion was provided by WHIN Coordinators

WHIN Coordinators provide health promotion and health information to students in various ways across the three Pilot sites. In some cases, WHIN Coordinators co-lead sessions, such as Seasons for Growth which teaches students how to cope with grief and loss and Zones of Regulation which helps students self-regulate their emotions. In other cases, health education was provided through relevant speakers organised by WHIN Coordinators. One WHIN Coordinator explained how they organised the local Women's Health Nurse to speak to students at school, leading to students identifying other services they can access in the community.

> **…so I got the Women's Health Nurse to come with me and I think that proved really valuable…it was really great to…go cool here's someone else in the community in Health that you can go to and then I came back the next Friday to school and there were about 6 girls said can you make us an appointment with the Women's Health nurse…**
>
> **WHIN Coordinator**

It was also highlighted that health education was provided when WHIN Coordinators informally interacted with students. Informal interactions allowed WHIN Coordinators to provide various types of health information, such as information related to sexual and mental health on an ad-hoc basis. For example, young people noted they often did not feel comfortable asking their parents or teachers for information on topics such as sex, contraception, or puberty and were less likely to access sexual health services. Students identified that the WHIN Coordinator was a trusted adult who could provide this more sensitive information to students, and they appreciated receiving this information from an adult who was not their parent or teacher. The evidence suggests that the provision of this information was crucial for breaking down the stigma of engaging with sensitive health topics, suggesting that the WHIN Coordinators can play an important role in the provision of health information and education. Ministry stakeholders highlighted this role is not the sole responsibility of the WHIN Coordinators and is a shared responsibility across schools, community and families.

WHIN Coordinators addressed barriers to healthcare and education

The evidence suggests that WHIN Coordinators supported students and families to overcome barriers to accessing health services or engage in education. These barriers included lack of access to transport, material (e.g. food, clothing), and financial, and were more apparent in the lives of low income and vulnerable families.

> **… Some [students have] a lot of family complexity and some housing and even…financial support needs…to be able to coordinate another support agency to go to Centrelink, set up bank accounts, provide all the kind of housing assistance, financial assistance in terms of food…all of that stuff is way beyond what we can do as a school.**
>
> **School staff**

To overcome these barriers, the WHIN Coordinators provided information or connected students with social and community services. WHIN Coordinators and school staff provided several examples of students who were able to apply for their driver's licence with the local WHIN Coordinators support, and noted that the WHIN Coordinators supported students to receive glasses by connecting families with financial support. The WHIN Coordinators themselves noted that they helped students from low socioeconomic families to access food and clothing and supported them to apply for Centrelink's Youth Allowance and to set up a bank account. Further, they pointed out that they connected vulnerable students with housing support, such as with Mission Australia. These financial and material barriers also impact on student's capacity to attend and engage in school and feedback from school staff indicated that addressing them can also support students to better engage in school, which school evidence indicates correlated with improved education outcomes. It also helped ensure they could receive needed health services.

Families with complex needs valued support provided by the WHIN Coordinator to improve student health and wellbeing

A school stakeholder spoke of a male student who often came to school without food and with a dirty uniform. The student was from a low socioeconomic family, was exposed to domestic violence, and his parents suffered from drug addiction. The student was referred to the WHIN Coordinator for support to address these issues. The WHIN Coordinator connected the child's parents to a drug rehabilitation service and regularly provided the student with clothing and food. The WHIN Coordinator also worked with the Department of Communities and Justice to ensure the student's safety. Following the intervention from the WHIN Coordinator, the student reported that their overall wellbeing has improved and that he felt more cared for. He was reported to be making more of an effort to learn and is speaking more openly about his family situation.

4. EVIDENCE OF IMPACT

This section of the report identifies the outcomes achieved by the WHIN Coordinator Model Pilot. This is based on consultations with WHIN Coordinators, members of the School Executive and staff, health and community service providers, parents, and students. These outcomes include outcomes for students and families, schools, the community and health and education systems.

4.1. OUTCOMES FOR STUDENTS AND FAMILIES

WHIN Coordinators enabled students and families to access support for their health and wellbeing needs by providing referrals to local health and community services. The referral outcomes for students varies between sites (see Figure 5 – WHIN Coordinator Referral Outcomes below). The most frequent referral pathways for each site are outlined below.

- Young - social services (n=50)
- Tumut - primary health care (n=63); social services (n=34)
- Cooma - mental health care (n=112); social services (n=92); primary health care (n=75).

This suggests that the WHIN Coordinators largely support students and families to connect with primary health and mental health care systems. Specific program data terminology is defined in the WPMT, and the data dictionary is provided in Appendix D. The high frequency of 'did not report' responses in Young is due to incomplete data collection.

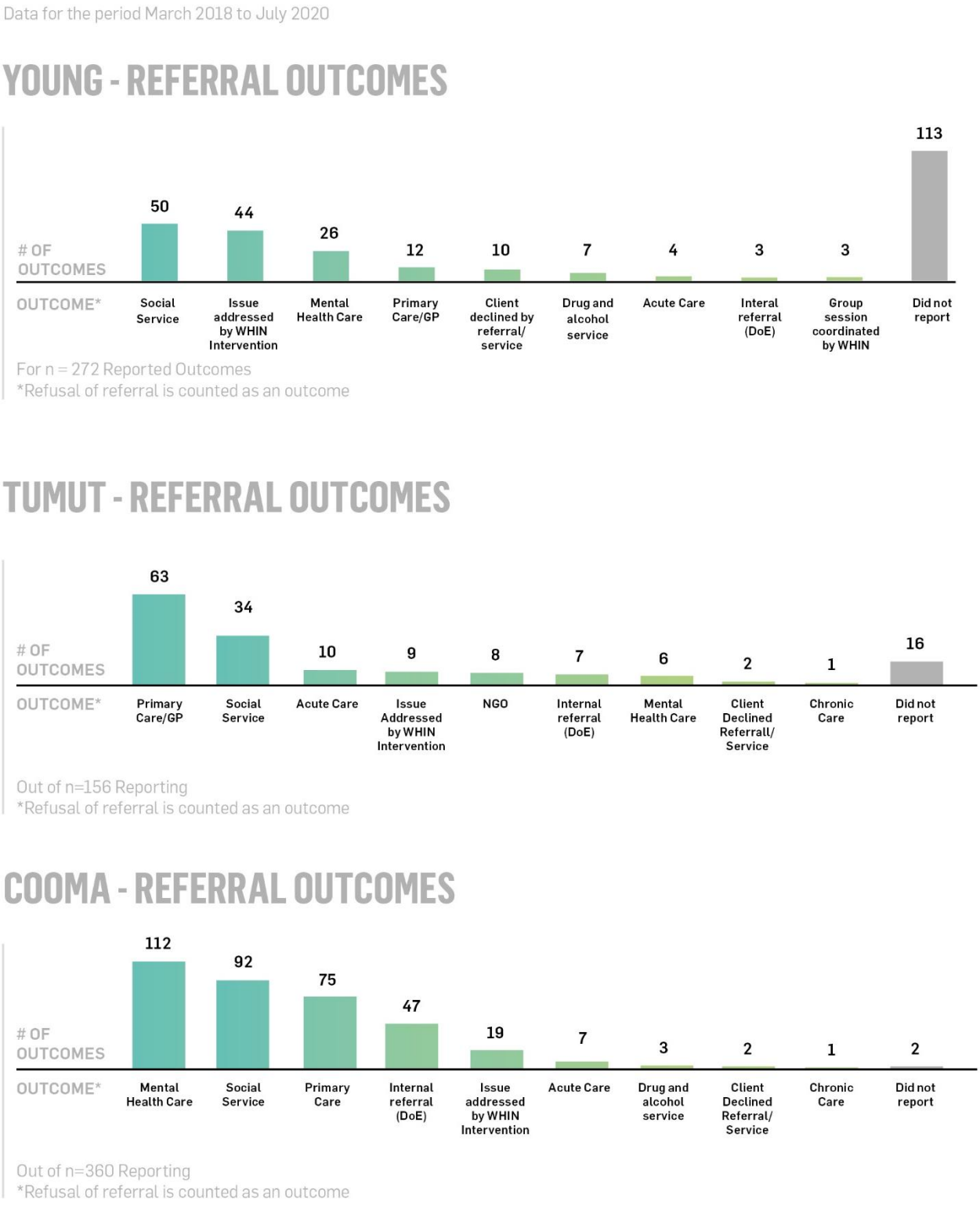
The attendance and suspension records of a sample of 95 students referred to the WHIN Coordinator between 15 October 2018 and 12 April 2019 was analysed to understand the educational impact of the WHIN Coordinator program. Student attendance rate and suspension records from the term immediately prior to their referral was compared with the equivalent term the following year. On average, the students in this sample experienced a 6% reduction in their attendance. However, there was a substantial reduction in the number of minutes lost for:

- unexplained or unjustified absence (82% reduction)
- illness (70% reduction), and
- explained or justified absence (58% reduction)

In addition, this group of students also experienced a reduction in the number (from 25 to 12) and duration (from 124 days to 100 days) of suspensions when comparing the term immediately prior to their referral to the WHIN with the equivalent term the following year.

The discrepancy between this group of student's overall attendance rate and the number of minutes for which they were absent indicates that while the frequency of absences increased, the duration of each absence decreased. When considered alongside their suspension records, this may suggest that WHIN Coordinators are able to help improve student attendance and engagement at school.

Figure 5 – WHIN Coordinator Referral Outcomes



Students and families experienced improved access to health services

The evidence strongly indicates that the WHIN Coordinator Model has improved student access to health services by addressing barriers to access. Perceived lack of privacy, embarrassment in disclosing health issues, stigma from seeking help, limited knowledge of available services, and distrust in health professionals, were some of the barriers cited by students, as well as school and community stakeholders. The WHIN Coordinators enabled students and families to address these barriers by providing support to navigate the service system and increase their comfort and confidence to access services through the provision of information and education.

It was commonly reported that many students and families had low levels of understanding of the service system. School staff and health and community service providers spoke of the WHIN Coordinators improving access to services by identifying appropriate service options, making referrals, and organising appointments. They also supported some students to attend appointments by providing transport. For instance, one school staff member explained that a student did not have sufficient medication for his Attention Deficit Hyperactivity Disorder (ADHD), and his mother did not fully understand how to obtain a new prescription. The WHIN Coordinator organised an appointment with a paediatrician, provided transport to the appointment, and supported the student to obtain the ADHD medication prescription. The student's behaviour has reportedly improved after resuming this medication.

WHIN Coordinators were further noted to improve access to services by providing health information and education that made students and families more comfortable accessing services. WHIN Coordinators and health and community service providers indicated that students and families sometimes lacked the knowledge and confidence to engage with the service system. WHIN Coordinators accordingly provided health information in simple and relatable language through school events and informal conversations. By providing information which increased knowledge of the health service system, the WHIN Coordinators strengthened the confidence of students and families to access services.

The WHIN Coordinator gave a student the confidence to attend a GP

A young person explained that she knew she was not feeling well but was apprehensive about visiting a GP as she didn't display any physical symptoms. She was able to connect informally with the WHIN Coordinator who explained the effects of mental health on physical wellbeing, and how a GP can help with both health and wellbeing issues, even if no physical symptoms are present. The student noted this information helped her to understand more about her mental health and that the WHIN Coordinator assisted her to attend a youth-friendly GP for a mental health assessment.

Students and families with complex needs improved engagement with the health system

WHIN Coordinators have been able to support students and families with highly complex issues, such as domestic violence, drug and alcohol abuse, severe mental health issues, issues of sexual abuse, sexual assault, physical and intellectual disability, and homelessness. These students and families were often not connected to the health system prior to engaging with the WHIN Coordinator. WHIN Coordinators noted that most families with complex needs have limited understanding of health and social services and very limited health literacy. For example, one school staff spoke of a family that did not understand how to schedule an appointment for their child. The school wellbeing systems were noted as not having sufficient time or knowledge to support students efficiently, and families navigate the health service system. WHIN Coordinators were able to spend the time and had the required depth of knowledge to understand and support families with complex health and social needs and to connect them to appropriate services. In contrast, school wellbeing staff have competing teaching responsibilities and non-specialised knowledge of the health system, meaning they commonly cannot efficiently provide the level of support families with complex needs require.

> **Students…now have better access to services than they would without the WHIN [Coordinator] because sometimes the systems for the services are so complicated and convoluted that it's very difficult to get access and [the WHIN Coordinator] has made this much more accessible, especially students with disadvantage in their lives and a lot of parents are illiterate or have low health literacy.**
>
> **School staff**

Supporting parents to overcome barriers to healthcare improves access to services

A WHIN Coordinator suggested that some parents are not connecting with specialists or attending booked appointments. They gave the example of one case involving a young person who had been diagnosed with and was taking medication for, Attention Deficit Hyperactivity Disorder. This 15-year-old was reportedly last reviewed by a paediatrician when he was six years old. He has been on the same medication since and his behaviour was becoming challenging. His mother told the WHIN Coordinator she didn't have the money for him to see a paediatrician and the WHIN Coordinator informed her that she knew of a paediatrician at the local community health service who 'bulk bills'. The WHIN Coordinator supported the mother to go through the process of taking her son to see a GP to obtain a referral to that paediatrician. Knowing that people often disengage with services when an appointment is several weeks ahead, the WHIN Coordinator put the date of the appointment into the mother's diary and then sent a reminder to the mother a day or two before. The engagement both reminded and encouraged the parent to attend the appointment with her child.

Emerging health issues in students were identified

There is evidence to suggest that WHIN Coordinators have been successful in proactively identifying emerging health issues of students, which may have otherwise gone unnoticed. WHIN Coordinators were reported as being in a unique position to assess health issues due to their experience and knowledge. This has enabled them to recognise warning signs such as changes in school attendance and performance, mood changes, complaints of illness, problems at home, or self-harm. For example, one WHIN Coordinator explained they noticed a student hyperventilating and experiencing heart palpations. The school believed this to be a cardiac issue, initially suggesting the student attend hospital. The local WHIN Coordinator's nurse training enabled them to identify that the student was experiencing a panic attack and therefore deduced they might have anxiety. Consequently, the student was connected to an appropriate mental health service for a comprehensive assessment. Another example was provided by a school stakeholder who reported a student from a low socioeconomic family was believed by school staff to be experiencing concentration and behavioural issues. The WHIN Coordinator met with the student and during the assessment identified the concentration issues might be due to poor vision and a need for reading glasses, which they could not afford. The WHIN Coordinator engaged with the student's family to connect them with an optometrist and financial support. The student now has glasses, and their concentration and behaviour in class has reportedly improved.

> **I feel like there are probably families that have accessed our service that wouldn't have beforehand because perhaps, the majority of our referrals come from FACS so if they don't meet that threshold potentially they don't get referred so [the Coordinator] has been able to pick up some of those ones that are getting towards that pointy end and been able to refer them before they get there.**
>
> **Community Stakeholder**

Students and families improved their health literacy

Consultation revealed that most students and families who engage with the WHIN Coordinator tend to have low levels of health literacy. School staff, community stakeholders and WHIN Coordinators all highlighted that many of these students and families lack a basic understanding of the health service system and do not have the confidence to liaise and schedule appointments with health professionals (see section 3.4). School staff, community stakeholders and young people all confirmed that WHIN Coordinators supported students and families to understand basic health information, available health services, and to make appropriate decisions about their health. This was achieved by using simple language and avoiding medical and clinical jargon and explaining health concepts. For instance, young people reported having difficulty understanding clinical terms related to physical and mental health, but the WHIN Coordinator was able to explain information in a way they could understand. This suggests that WHIN Coordinators support young people and families to better understand health information, enabling them to become active participants in their own care.

> **Talking to someone who actually knows what they're talking about. And she can break it down… all the specialists and paediatricians I've been to I've walked away and gone 'oh my god, I don't know what that meant.' I can go back to school and have another meeting with [the WHIN Coordinator] and say 'this is what they've said'…and she'll say 'this is what this actually means.'**
>
> **Parent**

Addressing health issues improved student attendance and engagement at school

When WHIN Coordinators support students and families to address health and wellbeing issues successfully, the evidence suggests that students may experience improved attendance and engagement at school. As discussed previously, by addressing family or other related factors, student wellbeing can improve and in turn, can increase their engagement with school. One school stakeholder provided the example of a student living in the context of family and domestic violence. The WHIN Coordinator worked with community support services to remove the violent partner from the family home and refer the student to an adolescent mental health service. The stakeholder reported that this intervention contributed to an improvement in the student's wellbeing and school attendance.

The consultations also suggested that addressing student health and wellbeing can improve behavioural issues, and thereby improve school engagement. By addressing underlying causes of behavioural issues, student's overall health and wellbeing improves, contributing to improved school engagement and attendance. For example, one school stakeholder reflected on a student with a record of poor behaviour and suspension, and with a history of trauma and drug and alcohol issues. The WHIN Coordinator connected the student to mental health and drug and alcohol services to provide them with appropriate support. The school stakeholder believed that with this support, the student experienced improved health and wellbeing, contributing to improved behaviour at school and a reduction in school suspensions.

> **His attendance, his wellbeing, is a lot better…the report cards from the end of last semester compared to the one 12 months before that, are polar opposites from each other. From basic achievements to or basic attendance in class to 'always' or 'somewhat' achieving.**
>
> **Parent**

Improved school attendance and engagement can contribute to improved learning outcomes, with students who are frequently absent or disengaged at school tending to have poorer academic performance compared to their peers (AITSL, n.d.). Some parents also explained that the WHIN Coordinator had been working with their child for an extended period to identify and implement strategies to manage the behaviour. In that time, their child's attendance at school was reported to have increased, and their grades have significantly improved.

Helping students and their families to address their health and wellbeing needs contributed to improved school engagement

A WHIN Coordinator gave the example of a secondary student with significant behavioural issues leading to frequent suspensions and preventing them from attending mainstream classes. During their initial assessment of the student, the WHIN Coordinator noticed there might be underlying health issues causing this behaviour. The WHIN Coordinator then organised for the student to attend a vision assessment with an ophthalmologist, who identified the student had significant vision issues and required glasses. The WHIN Coordinator also organised a paediatric appointment who assessed and diagnosed the student with ADHD. The student subsequently received reading glasses and was prescribed medication for ADHD. Within four weeks of receiving glasses and commencing medication, the student had re-engaged with school in a special education stream and is trialling attendance in mainstream classes. The school believes the student is on track to return to mainstream classes fulltime within two months.

4.2. OUTCOMES FOR SCHOOLS

The WHIN Coordinator Model increased the time teachers can focus on their teaching duties

School staff responsible for student wellbeing commonly reflected that before the introduction of the WHIN Coordinator, they provided some case management and care coordination, but lacked sufficient knowledge of available health services to ensure students and their families could efficiently access support. School Executive and staff noted that with the introduction of the WHIN Coordinator, school staff spent less time on case management and care coordination, allowing school staff to prioritise leadership, teaching and counselling. For example, one school stakeholder specifically reflected on the extensive time it could take to access support for students through the Mental Health Access Line; a process made *"so much easier and efficient"* with the WHIN Coordinator's assistance.

The WHIN Coordinator Model helps schools to better support student health and wellbeing needs

Schools are particularly well-placed to support the health and wellbeing of students, as students attend school for up to 30 hours per week, providing ongoing opportunity to observe students' behaviour and needs. School Executives consistently suggested that the WHIN Coordinator's nursing background provided additional expertise to their school wellbeing teams, improving their ability to identify student needs.

WHIN Coordinators are reportedly often better able to proactively identify emerging issues with students by noticing symptoms that a parent or other health or community service may miss. For example, one School Executive highlighted that the WHIN Coordinator noticed a student who appeared consistently unhappy. After some gentle questioning, the WHIN Coordinator discovered the student was experiencing a difficult family situation leading to some mental health issues.

The WHIN Coordinator Model also enables schools to better engage students in wellbeing support services. Students sometimes perceived that there is stigma attached to attending school wellbeing services as they are primarily associated with supporting a student's mental health. The WHIN Coordinator, in contrast, was perceived to have a broader remit.

Finally, school and community stakeholders recognised that the WHIN Coordinator's health expertise can assist with the identification of health and wellbeing issues which may be contributing to a student's behavioural problems. This enables schools to provide targeted support, rather than a behavioural solution (such as detention or suspension), to address student behaviour. Several accounts were made of the WHIN Coordinator assessing students presenting with behavioural issues and identifying health and wellbeing issues (such as underlying hearing or sight, nutrition, or concentration issues) that may have contributed to their poor behaviour.

> **[It has] become such an integral part of our whole learning support and Wellbeing Framework in our school, I don't know what we'd do without it now. What is unique is our Department don't provide those resources, we have a wonderful Wellbeing Framework, but it is limited…**

School Executive

> **…it makes school…understanding and caring place, not just an education place…it's all very well to have a wellbeing framework tagged on the noticeboard but they're actually living their wellbeing framework by making appropriate referrals or increasing referrals to school counselling, to the school wellbeing nurse…**

WHIN Coordinator

> **You go to a health professional, you're there for an hour, you can behave in a certain way, a family can behave in a certain way when they're for that appointment whereas at a school we see…these children for 30 hours a week, we're seeing them consistently…a lot of need is picked up within a school that even parents aren't aware of until they bring the child to school and point it out and we identify things and say 'oh that's not particularly atypical behaviour…'**

School Executive

4.3. OUTCOMES FOR COMMUNITY

Holistic and collaborative service provision strengthened across local services

Health and community service providers and WHIN Coordinators confirmed the Model has supported and empowered local services to work together and with schools to meet the needs of students, particularly those with complex needs. WHIN Coordinators appear to support community and school wellbeing services to work more collaboratively together, by acting as a coordinator and conduit for information. For example, a community service provider reflected on working with the WHIN Coordinator, the school counsellor, and another service provider, to support a family. The WHIN Coordinator organised one service to develop a case plan for the parent, the other to provide support for drug and alcohol abuse, and the school counsellor to provide ongoing mental health support, while the WHIN Coordinator supported the student through behavioural issues. By bringing together the expertise and skills of different professionals, the WHIN Coordinator could facilitate holistic care for the student and their family.

> **When we all worked together, the relationship between students and parents have become a lot better…the holistic approach was really important.**
>
> **Health and community service providers**

Services provided effective care with the support of feedback from WHIN Coordinators

The WHIN Coordinator's regular contact with students was highlighted as supporting ongoing assessment and treatment through the provision of timely feedback to services. Health and Community service providers explained that their local WHIN Coordinator provided regular updates about a student's progress at school or with treatment, as well as other health, wellbeing, and family issues a student might experience. This was something that schools were reportedly unable to provide due to time or confidentiality constraints, and their otherwise limited engagement with local health and community service systems. Service providers noted that this information enabled them to better manage the support they provided for a student. One service provider reported that the WHIN Coordinator providing updates about a student and their family background *"has made [their] therapy more effective"*. Another service provider believed that receiving ongoing updates about a student's mental health supported them to provide more targeted support for their drug and alcohol issues.

> **It's the ability to make that phone call or go down and have the conversation, have the cup of coffee, how is that happening rather than just sending an email and hoping for the best or leave a message and hope for the best. Time constraints are a big issue.**
>
> **School Executive**

4.4. OUTCOMES FOR SYSTEMS

The WHIN Coordinator Model connected and coordinated education, community, and health support systems

As previously discussed, the WHIN Coordinators have successfully connected schools with community and health services. In addition, school and health and community service providers confirmed that having a WHIN Coordinator invest time engaging with students and families and sharing information between services enabled school wellbeing and local service delivery to become more efficient. School Executives often described WHIN Coordinators as *"standing at the school gate"*, providing a connection between school-based wellbeing support and the local health and community service system. School Wellbeing Teams are often unable to facilitate the same degree of connection with local service systems due to time or confidentiality constraints. Many school stakeholders explained that without the WHIN Coordinator, their ability to connect and coordinate with local services was significantly diminished. Service providers also reported that when a school had a WHIN Coordinator, they spent less time seeking referrals and following up with students, enabling them to focus on treating and supporting clients.

> **As educational experts, we don't necessarily know all of the avenues for all of the referral pathways, but our health sector colleagues do.**
>
> **School Executive**

WHIN Coordinators undertook early-intervention activities which reduced engagement with acute care

The WHIN Coordinators, school stakeholders, and community stakeholders suggested that WHIN Coordinators have engaged in early intervention and care planning with students to link them with appropriate primary health care services. This early intervention can help reduce unplanned hospital admissions and the use of emergency services. By supporting students to engage with primary health care, it appears the WHIN Coordinator Model can reduce engagement with acute care services. For example, one student noted that prior to engaging with the WHIN Coordinator, they would present to the emergency department for help with their mental health. The WHIN Coordinator has supported them to connect with a GP who helped them develop a mental health support plan, and visits to the Emergency Department are no longer necessary.

A WHIN Coordinator supported a student out of the acute care system

A WHIN Coordinator provided the example of a student who had been referred by a local mental health service. The student was experiencing homelessness after a breakdown in her foster care placement and had been admitted to hospital for mental health support. The WHIN Coordinator liaised with an out-of-home care provider to secure emergency accommodation, and later a referral was made to the YMCA Youth Centre to provide housing advocacy and social support. They also supported the completion of a Centrelink Youth Allowance application, organised an appointment with a GP to obtain a prescription for urgent medication, and made a referral to headspace for ongoing mental health support. Additionally, the WHIN Coordinator supported the student to re-enrol at school.

The student now has stable housing and is attending school on a vocational study pathway. The student provided feedback to the WHIN Coordinator that she '*could not believe how quickly she was able to leave hospital'*, find safe accommodation and recommence her education. Without the WHIN Coordinator's support to connect her with primary health care and local social services, the student may have required an extended admission to hospital.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. OVERALL CONCLUSIONS

A novel approach to supporting the health and wellbeing of children and young people was tested with the introduction of the WHIN Coordinator Model Pilot in 2018. While the addition of a health professional to school campuses has not always been easy, the data available for this evaluation suggests that WHIN Coordinators have been successful in providing tailored care and support to nearly 800 students between 1 March 2018 and 31 July 2020. Upon Pilot inception, it was anticipated that WHIN Coordinators would primarily offer prevention and early intervention services; however, they have in fact played a role managing complex cases, including students with experience of severe mental health issues, sexual assault, and the suicide of family members. This highlights a need for a clear Scope of Practice and robust clinical governance processes, as well as a support system for the WHIN Coordinators, who are collocated in schools work outside the health system. Throughout the Pilot, the need to employ an experienced registered nurse to fulfil the WHIIN Coordinator role has been debated by the Steering Committee. This evaluation has highlighted clear benefits to the WHIN Coordinator role being undertaken/filled by a nurse, rather than another health professional or specialist teacher; most notably:

- The WHIN Coordinators' nurse training and experience means they are able to consider health holistically, assessing a student's physical and psychosocial health in the context of family and community environments. It should be noted that nursing professionals who have worked in, paediatrics, child and youth health or child and adolescent mental health appear to be especially suited to the position. Further, sufficient experience to work as an autonomous health practitioner and an in-depth understanding of the health and local community service landscape is essential.
- Nurses are well-respected within the health system and can communicate capably with a wide variety of health professionals, regardless of whether the discussion is focussed on physical or mental health issues. While untested, the evidence collected for this evaluation suggests it is unlikely that a different type of clinician (or a teacher) would have the same level of traction with the health system. A nurse is also a unique profession within the school-based wellbeing team and as such, brings a unique set of knowledge and skills.

As with most Pilots, there have been significant learnings related to Model design and governance through this early stage of implementation. Most notably, the WHIN Coordinator Model appears to work best when:

- the WHIN Coordinator is a school-based wellbeing nurse, who has the capacity and capability to work within a school, outside a health setting
- the WHIN Coordinator focuses on developing and maintaining strong relationships with students, families, schools, and local services
- the Model is supported by the NSW Health and the Department of Education at a whole-of-Model, site, and school level.

The evaluation drew attention to how Model success can be impacted by school level processes and relationships, particularly during establishment. Put simply, the Model is most successful when the WHIN Coordinator and school staff have a shared understanding of the WHIN Coordinator's role and, especially, the value the role can add to a school's health and wellbeing systems. It is also necessary for the WHIN Coordinator to fully comprehend and ideally be embedded in these systems, with a focus on understanding the types of support provided by other school staff, before commencing any form of clinical practice – this may take several months. Success at a site or school level could be enhanced through the establishment of stronger collaboration between NSW Health and Department of Education stakeholders, assuring teachers, school staff, and the WHIN Coordinators of the safety and usefulness of the Model in all circumstances.

When well established and integrated with school systems, the Model has the potential to be effective for improving health and education outcomes for students and families through:

- identifying and assessing health and wellbeing needs
- improving access to health and social services
- addressing barriers to service access and school engagement.

The Model also has the potential to enable schools and local service systems to provide better support for vulnerable students by strengthening their individual processes and increasing collaboration to provide holistic and integrated care. This in turn, may have the potential to contribute to wider benefits to local health and social service systems where WHIN Coordinators operate.

5.2. CONSIDERATIONS FOR SUSTAINABILITY AND SCALABILITY

The WHIN Coordinator Model is well placed to achieve improved health and educations outcomes by positioning the WHIN Coordinator as a school-based wellbeing nurse who works across the community

The evidence suggests that for the WHIN Coordinator Model to continue to be successful, it is essential that the role be a school-based 'wellbeing nurse', who adopts a holistic and comprehensive approach to the health of children, young people, and families.

As noted above, the evidence suggests there is value in the WHIN Coordinator role being held by an experienced nurse with knowledge and experience in child and family health, paediatrics or youth health, and that the nurse role should be reflected in the position title. The evidence also highlights the importance that the Model continues to operate on school grounds, as it improves visibility and accessibility, and helps to establish and strengthen relationships with staff, students, and their families. The existence of the WHIN Coordinator Model in the school environment reportedly supports students and families to overcome barriers to access services. Additionally, it reportedly supports relationships to be formed and strengthened with school staff due embedding the position in the school to support regular communication with school staff and attendance at school meetings.

While the WHIN Coordinators' services are mainly delivered on school campuses, the flexible approach to engagement across the community appears to be critical to continued success. The Model should continue to be mobile, involving relationship-building across the community and liaising with key community stakeholders to ensure the WHIN Coordinators can remain connected with local health and social service systems. For example, attending interagency meetings and meeting with community services reportedly enables WHIN Coordinators to develop rapport and relationships that help them facilitate referrals for students. Working across the community also helps WHIN Coordinators facilitate access to services, such as by providing transport. As such, it is important than WHIN Coordinators have the capacity and capability to work independently within a community-based non-health setting.

Service delivery is most effective when underpinned by strong relationships with students, school stakeholders, and community services

The evidence suggests that as the Model is underpinned by a relational-based service delivery model. Maintaining strong relationships within and between school community service systems, as well as with students and families, is therefore critical to ongoing success and scalability.

Relationships within school and service systems

WHIN Coordinators were highlighted as building strong relationships with school, health, and community stakeholders to support the holistic care of students and families. As discussed in Section 2.1, the Model appeared to successfully integrate into schools when WHIN Coordinators frequently communicated with the School Executive and Wellbeing Team staff and regularly attended team meetings. These activities contributed to WHIN Coordinators reportedly establishing trusting relationships with school stakeholders and allowed them to play an active role supporting schools to assess and manage students with health and wellbeing concerns.

WHIN Coordinators were also reported to have a robust knowledge of and strong relationships with local health and social services. These relationships were further strengthened by frequently attending interagency meetings and communicating with services about students' care. These relationships allowed WHIN Coordinators to connect students with relevant health and community services and receive timely feedback about students' progress. Feedback from stakeholders suggested that ensuring WHIN Coordinators had the time to foster relationships within each school they supported, and with the broader service system was essential to the success of the Model.

Relationships between school and service systems

As discussed in Section 3.4, the evidence suggests that WHIN Coordinators facilitate the relationship between school and health and social service systems. Feedback from consultations indicated that school staff lack sufficient time and knowledge to effectively coordinate students' health care, including facilitating their connection to external services. Similarly, community services have reported difficulty engaging with schools to identify students that may require support from their services. As WHIN Coordinators have relationships within each of those systems, they are uniquely placed to facilitate collaboration. The WHIN Coordinators appeared to have strengthened relationships between the two systems by collecting and

sharing information relevant to the care of students and their families. This enabled WHIN Coordinators to feedback relevant information to health and community services and school staff, supporting them to provide effective health care and learning support. Connecting the two systems through relationship-building is important for ensuring students and families receive holistic and integrated care.

Relationships with students and families

WHIN Coordinators are commonly the only ongoing relationship which a student or family has across a local health and social service, and education system. Further, consultations suggested that students and families often feel comfortable receiving ongoing support from the WHIN Coordinators, as they can spend time engaging and building rapport. By taking the time to maintain relationships, following up with students and families on their progress, and helping overcome barriers, WHIN Coordinators can help facilitate a continuity of care that is otherwise unlikely to occur. The time WHIN Coordinators are able to focus on providing extensive support to students and families is a unique aspect of the Model that should be maintained.

A partnership approach to Model management should clearly articulate expectations, governance, and lines of accountability

It is critical for success that the Model is underpinned by a robust partnership between NSW Health and the NSW Department of Education stakeholders at all levels of governance (whole-of-Model, site and school). The evidence indicates this works best when expectations, decision-making and accountability structures are clearly defined at each level, and all relevant stakeholders are actively involved in Model management.

Features of the Model that appear to support a successful partnership approach to Model management include:

- Consistent, dual representation from the NSW Ministry of Health and the NSW Department of Education at the whole-of-Model level, with clearly defined roles and responsibilities for implementation, accountability, and management
- Model management and operational management and clinical supervision by LHDs to assist with clarifying the Coordinator's roles and responsibilities at the site and school governance level
- WHIN Coordinators attending staff meetings and providing frequent updates on Model implementation and performance to School Executive at the school governance level
- School leadership championing and promoting the WHIN Coordinator Model, including clarifying referral pathways to the service within the school.

To encourage collaboration between stakeholders, it is crucial the establishment phase of any site allows adequate time for the Model to be introduced and refined for the local school and service systems. These arrangements should be periodically reviewed to maintain the engagement of relevant stakeholders and ensure the Model continues to meet the needs of both the NSW Health and the NSW Department of Education.

5.3. EVALUATION ASSESSMENT

The WHIN Coordinator Model aimed to achieve several outcomes to improve the health and wellbeing of children and young people. Collectively, evidence suggests the WHIN Coordinator Model contributed to the achievement of each outcome to varying degrees. Table 4 below summarises the extent to which the Model achieved each outcome.

Table 4 – Evaluation assessment of the WHIN Coordinator Model Pilot

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
Foundational Activities	
Management and Governance Establish Steering Committee and governance arrangements; set out the collaborative relationship between NSW Health and the NSW Department of Education, set model of care and service delivery model(s); develop key performance indicators (KPIs) and mechanisms for reporting against KPIs (throughput, referral rates, and so on)	**Mostly achieving** ▪ Management and governance frameworks are established at a whole-of-Model, site, and school level ▪ Accountability has improved during the Pilot, but the effectiveness of governance frameworks varies across the sites
Implementation Develop scope of practice for WHIN Coordinators; engage stakeholders and hire WHIN Coordinators; establish work environments and resources, establish occupational health and safety, and insurance arrangements, engage local stakeholders	**Partly Achieving** ▪ All WHIN Coordinators positions are filled, staff are operating from established work environments, and have engaged with local stakeholders ▪ Integration and compatibility of data and technology between the Health and Education systems continue to impede the WHIN Coordinator's ability to fulfil their role.
Outputs	
Partnerships established with local schools and service providers	**Achieving** ▪ Partnerships between WHIN Coordinators and schools and local service providers have been established at all sites
Students referred to WHIN Coordinator	**Achieving** ▪ All WHIN Coordinators receive referrals via formal and informal mechanisms, continuously.
Students (and families) triaged and connected with local service providers	**Achieving** ▪ All WHIN Coordinators assessed the needs of students and families and connected them with local service providers.
WHIN Coordinator provides opportunistic health education and promotion to school communities (one-on-one and group; not in classroom)	**Achieving** ▪ All WHIN Coordinators provide health education and promotion through both formal and informal channels
Short term outcomes	
Increased access to health and social services by students and families	**Achieving**

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
	▪ Many students and families accessed health and social services with support from the WHIN Coordinator, where otherwise they would have been unable
The WHIN Coordinator Model has been successfully incorporated into a whole-of-school approach to student wellbeing (as available)	**Mostly achieving** ▪ Schools have integrated the WHIN Coordinator Model with existing wellbeing systems, but the clarity and consistency of role with these systems varies across sites.
Student (and family) health and wellbeing needs are identified	**Achieving** ▪ All WHIN Coordinators frequently identified health and wellbeing needs of students and families. ▪ Students presented most frequently to the WHIN Coordinator for mental health concerns (246 instances), social support (222 instances), and behavioural symptoms (126 instances)
Students (and families) access affordable and appropriate local services and programs	**Achieving** ▪ WHIN Coordinators connected students and families with social services (176 instances), primary health care (150 instances), and mental health care (144 instances). ▪ Unexpected factors, such as reduced service availability due to COVID-19, prevented WHIN Coordinators from supporting some students and families to access appropriate services and programs.
Student (and family) health and wellbeing needs are addressed on an ongoing basis	**Insufficient evidence available** ▪ Two-thirds of referrals to the WHIN Coordinator were resolved within two months. ▪ Qualitative evidence suggests that WHIN Coordinators had a brief intervention with most students and families to triage the case and provide a warm referral to an appropriate service. In the context of the Model, this was an appropriate response. ▪ No evidence is available to measure student and family's ongoing engagement with services.
Students are motivated to participate and engage in school	**Mostly achieving** ▪ Qualitative evidence suggests that WHIN Coordinators mostly support students to overcome health and other barriers to participating and engaging in school.
Parents are able to support students to achieve positive health and education outcomes	**Insufficient evidence available.**
Intermediate outcomes	
Positive health and education outcomes for students and families	**Emerging evidence** ▪ Qualitative evidence suggests the WHIN Coordinator supports many students and families to address health and wellbeing needs that they would otherwise be unable to resolve.

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
	▪ Qualitative and quantitative evidence suggests that students who access the WHIN Coordinator experience improved attendance and engagement with school, which the literature correlates with improved education outcomes. ▪ Case studies of a sample of students and families supported by the WHIN Coordinators demonstrate that positive health and education outcomes have been achieved
Local health and human services provide coordinated care to student and families	**Mostly achieving** ▪ Qualitative evidence indicates that WHIN Coordinators often connected school and community service systems to ensure students and families received holistic support.
School teachers and leadership devote less time to case management	**Sometimes achieving** ▪ Qualitative evidence suggests that in some instances, WHIN Coordinators enabled school staff to reduce their case management workload.
Student health and wellbeing is improved	**Early evidence** ▪ Qualitative evidence suggests that many students who engaged with the WHIN Coordinator experienced improved health and wellbeing.
Students are engaged and participating in school	**Early evidence** ▪ Qualitative evidence suggests that WHIN Coordinators support students to participate and engage in school by addressing health and other barriers to school engagement and participation. ▪ The sample of student attendance data analysed showed that while the attendance rates decreased after a WHIN intervention, there was a substantial reduction in the amount of time students were absent for unexplained reasons (82% reduction), illness (70% reduction), and approved reasons (58% reduction).
Students have a sense of connectedness and belonging to the school community	**Insufficient evidence available** ▪ Anecdotal reports suggest some students feel a sense of connectedness and belonging to the Care Connect Hub in Young.
Vulnerable students and families are physically and emotionally safe	**Early evidence** ▪ Qualitative evidence suggests vulnerable students and families supported by WHIN Coordinators to access health and social services showed improvement in their physical and emotional safety, but further evidence is required.
Long-term outcomes	
Optimal health and wellbeing outcomes for children and young people	Outside scope of evaluation

OUTPUT/OUTCOME	ACHIEVEMENT AS AT AUGUST 2020
Optimal education outcomes for children and young people	Outside scope of evaluation
Impact	
Children and young people are safe and achieving their full potential	Outside scope of evaluation

5.4. RECOMMENDATIONS

Drawing together evidence collected for this evaluation and the assessment above, we put forward the following recommendations for the ongoing implementation of the WHIN Coordinator Model. Two further points should be noted:

(c) These recommendations were developed with the knowledge that since the introduction of the Pilot, the Model has been expanded to a further three sites. In addition, in November 2020, the NSW Government has announced that the program would be expanded to create 100 new WHIN Coordinator positions.

(d) When making decisions about the future of the Model, attention should also be given to the considerations for sustainability and scalability included in Section Five of this report.

Recommendation one: The Ministry and Department of Education should undertake a detailed operational review of existing sites.

This should assess the performance and operation of each Pilot site to determine fidelity to the success enablers identified in this evaluation. Where necessary, local adjustments to the Model should be made at each site to improve implementation success and outcomes achieved.

Recommendation two: The Ministry and Department of Education should undertake a review of governance at whole-of-Model, site, and school level.

This should assess performance in terms of the following factors and adjust as necessary:

- Membership, roles, and responsibilities of governance groups
- Monitoring and reporting of Model performance
- Management of clinical and operational risk

Recommendation three: The Ministry and Department of Education should review the model of care and service delivery model based on evaluation findings and update as necessary.

This process should, at a minimum, include the following key steps:

- Undertake a Model review process using evaluation findings to adjust:
  - the program logic, indicators of success, and model of care to reflect the outcomes which the evidence suggests the program can be expected to achieve (i.e. is it reasonable to expect the program to address student (and family) health and wellbeing needs an ongoing basis)
  - governance and reporting processes to ensure quantitative evidence for the Model's impact on education and health outcomes is collected (i.e. collecting data on school attendance and ongoing engagement or discharge from health or social services) and
  - Model guidelines and partnership arrangements for roles, responsibilities, and delegations of authority
- Develop an approach to collect and link Model-specific health and education data to improve the measurement and evaluation of outcomes
- Distribute comprehensive documentation of an tweaks to the Model (including program logic, indicators of success, model of care, governance and reporting arrangements, suggested integration with existing systems) to provide clarity and support sites and schools make local adjustments to respond to local context.

Recommendation four: The Ministry and Department of Education should develop an implementation strategy to guide the establishment phase for any new sites to ensure lessons from the formative evaluation are applied.

This Strategy should include the adoption of 'testing phase', to assess potential new sites for feasibility and readiness before commencing any establishment processes, with the option of not proceeding with establishment if the site is not currently suitable or set up for success.

In addition, as the program expands monitoring and evaluation processes will be critical to supporting the success of the program. Incorporating evaluative thinking into the implementation and delivery of an expanded Model will support the Steering Committee and Local Governance Committees to make evidence-informed decisions. Further, commissioning a process evaluation in parallel to Model expansion will provide the Steering Committee with independent analysis and advice to inform ongoing implementation. The Steering Committee may also consider commissioning an operational review of new sites to ensure local adjustments adhere to the Operating Guidelines.

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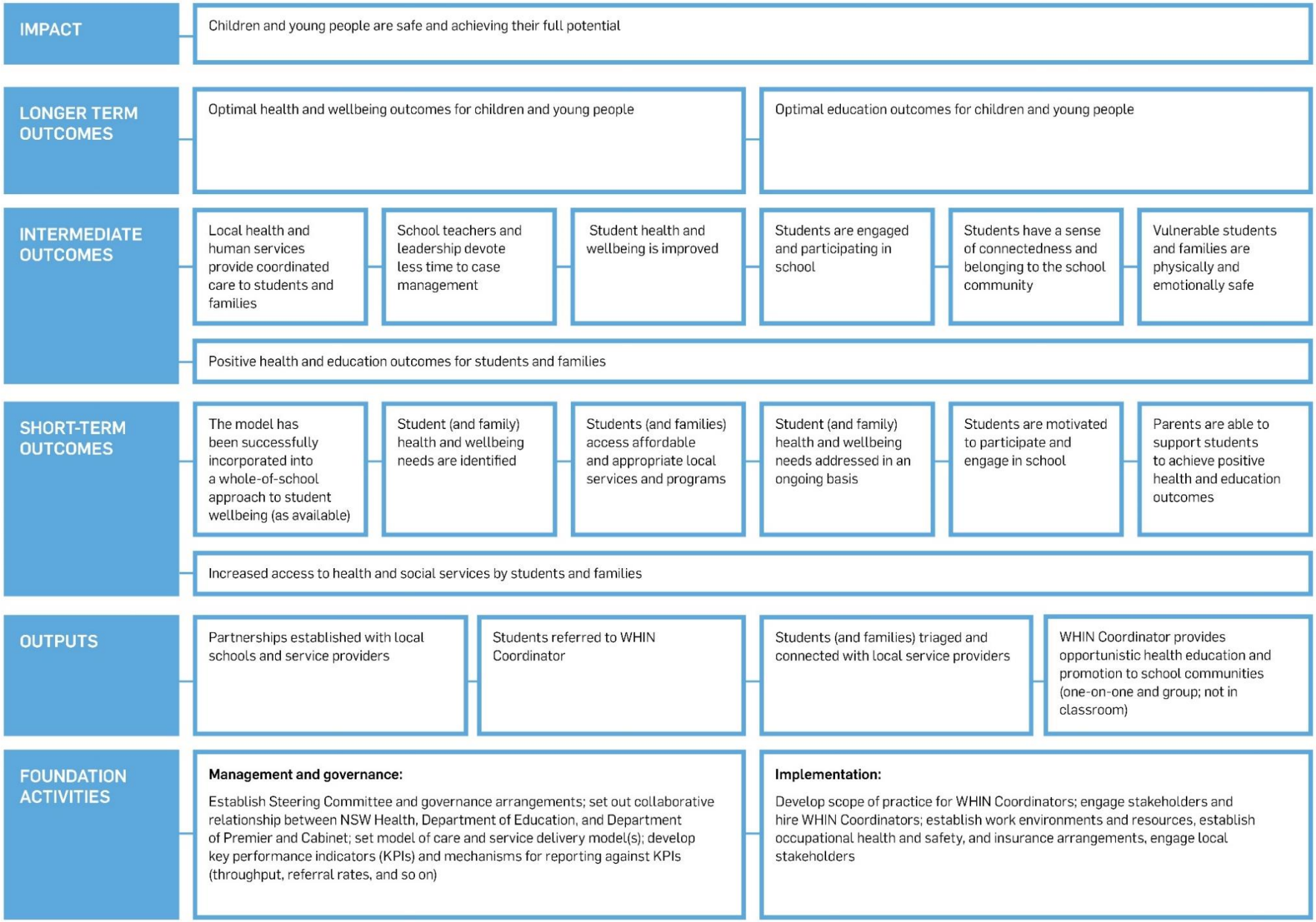
This report has been prepared with due care and diligence by Urbis and the statements and opinions given by Urbis in this report are given in good faith and in the reasonable belief that they are correct and not misleading, subject to the limitations above.

APPENDIX A PROGRAM LOGIC AND EVALUATION FRAMEWORK


IMPACT
Children and young people are safe and achieving their full potential
LONGER TERM OUTCOMES
Optimal health and wellbeing outcomes for children and young people
Optimal education outcomes for children and young people
INTERMEDIATE OUTCOMES
Local health and human services provide coordinated care to students and families
School teachers and leadership devote less time to case management
Student health and wellbeing is improved
Students are engaged and participating in school
Students have a sense of connectedness and belonging to the school community
Vulnerable students and families are physically and emotionally safe
Positive health and education outcomes for students and families
SHORT-TERM OUTCOMES
The model has been successfully incorporated into a whole-of-school approach to student wellbeing (as available)
Student (and family) health and wellbeing needs are identified
Students (and families) access affordable and appropriate local services and programs
Student (and family) health and wellbeing needs addressed in an ongoing basis
Students are motivated to participate and engage in school
Parents are able to support students to achieve positive health and education outcomes
Increased access to health and social services by students and families
OUTPUTS
Partnerships established with local schools and service providers
Students referred to WHIN Coordinator
Students (and families) triaged and connected with local service providers
WHIN Coordinator provides opportunistic health education and promotion to school communities (one-on-one and group; not in classroom)
FOUNDATION ACTIVITIES
Management and governance:
Establish Steering Committee and governance arrangements; set out collaborative relationship between NSW Health, Department of Education, and Department of Premier and Cabinet; set model of care and service delivery model(s); develop key performance indicators (KPIs) and mechanisms for reporting against KPIs (throughput, referral rates, and so on)
Implementation:
Develop scope of practice for WHIN Coordinators; engage stakeholders and hire WHIN Coordinators; establish work environments and resources, establish occupational health and safety, and insurance arrangements, engage local stakeholders

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
Children and young people are safe and achieving their full potential	Outside scope of evaluation	Outside scope of evaluation	Outside scope of evaluation	Outside scope of evaluation
Children and young people are achieving optimal	Outside scope of evaluation	Outside scope of evaluation	Outside scope of evaluation	Outside scope of evaluation
Children and young people are achieving optimal health and wellbeing outcomes	Outside scope of evaluation	Outside scope of evaluation	Outside scope of evaluation	Outside scope of evaluation
Vulnerable students and families are physically and emotionally safe *(Indirect measure of program success)*	▪ To what extent are vulnerable students and/or families in the pilot catchment physically safe? ▪ To what extent are vulnerable students and/or families in the pilot catchment emotionally safe?	▪ Perceptions of physical safety amongst students/families who engaged with the pilot ▪ Perceptions of emotional safety amongst students/families who engaged with the pilot *[Note that a process for managing student distress or Risk of Significant Harm will be developed as part of the ethics application]*	▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders	Intermediate outcomes
Students have a sense of connectedness and belonging to the school community *(Indirect measure of program success)*	▪ To what extent has the pilot contributed to students within the catchment feeling connected to their school community?	▪ Perceptions of connectedness to school by students who have engaged with the pilot (group or one-on-one) ▪ Perceptions of overall school connectedness pre- and post-pilot by school management, frontline staff, WHIN Coordinators, and other stakeholders	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders ▪ Survey of all stakeholders	Intermediate outcomes
Students are engaged and participating in school *(Indirect measure of program success)*	▪ To what extent does engagement in the pilot (group or one-on-one) contribute to an increase in school attendance? ▪ To what extent does engagement in the pilot (group or one-on-one)	▪ Education outcomes for students who engage with the pilot (group or one-on-one; subjective and objective measures) ▪ Pre- and post-pilot school attendance, engagement, and retention rates (as available)	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders ▪ Survey of all stakeholders	Intermediate outcomes

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
	contribute to an increase in school engagement? ▪ To what extent does engagement in the pilot (group or one-on-one) contribute to an increased likelihood of students remaining in education?		▪ Administrative and clinical data	
Student health and wellbeing is improved *(Indirect measure of program success)*	▪ To what extent has the pilot contributed to improved health and wellbeing of students within the catchment? ▪ To what extent does engagement in the pilot (group or one-on-one) by students contribute to increased health-seeking behaviours? ▪ To what extent does engagement in the pilot (group or one-on-one) by students contribute to decreased risk-taking behaviours?	▪ Health and wellbeing outcomes for students who engage with the pilot (group or one-on-one; subjective and objective measures) ▪ Number and type of health-seeking behaviour undertaken by students engaged with the pilot (group and one-on-one) ▪ Number and type of risk-taking behaviour ceased by students engaged with the pilot (group and one-on-one)	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders ▪ Survey of all stakeholders ▪ Administrative and clinical data	Intermediate outcomes
School teachers and leadership devote less time to case management *(Indirect measure of program success)*	▪ To what extent are teachers and leadership devoting less time linking students to local services?	▪ School management and frontline staff perceptions on the amount of time spent case managing	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff	Intermediate outcomes

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
Local health and human services provide coordinated care to students and families *(Indirect measure of program success)*	▪ To what extent are health and human services within the pilot catchment efficiently addressing the health and wellbeing needs of students and/or families?	▪ Availability of local health and human services ▪ Wait times for local health and human services (approximate if quantitative data is not available) ▪ Student and parent perceptions on whether their health and wellbeing needs are being efficiently addressed ▪ Local service provider perceptions on whether the health and wellbeing needs of students and/or families are being efficiently addressed	▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders ▪ Survey of all stakeholders ▪ Administrative and clinical data	Intermediate outcomes
Parents can support students to achieve positive health and education outcomes *(Indirect measure of program success)*	▪ To what extent are parents able to support students to achieve positive health and education outcomes?	▪ Parent perceptions of their knowledge of, and confidence in accessing, local services ▪ School management and frontline staff perceptions of parents' capacity to support students	▪ Interviews with school management ▪ Interviews with other stakeholders (including parents) ▪ Interviews with WHIN Coordinators and frontline staff	Short-term outcomes
Students are motivated to participate and engage in school *(Indirect measure of program success)*	▪ To what extent has the pilot contributed to an increase in student motivation to participate and engage in school?	▪ Level of student motivation pre- and post-pilot (self-reported) ▪ School management and frontline staff perceptions on student motivation pre- and post-pilot commencement	▪ Interviews with school management ▪ Focus groups with young people ▪ Interviews with WHIN Coordinators and frontline staff ▪ Administrative data	Short-term outcomes

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
Student (and family) health and wellbeing needs to be addressed on an ongoing basis *(Indirect measure of program success)*	▪ To what extent are students and parents regularly accessing primary care and other services?	▪ Local service provider, school management and young people's perceptions on regular service access ▪ Number and type of relationships established between students/parents and local service providers (approximate if quantitative data is not available)	▪ Interviews with school management ▪ Focus groups with young people ▪ Interviews with WHIN Coordinators and frontline staff ▪ Administrative and clinical data	Short-term outcomes
Students (and families) access affordable and appropriate local services and programs *(Indirect measure of program success)*	▪ To what extent are students and parents within the pilot catchment accessing appropriate local health and social services/ programs? ▪ To what extent do students and parents in the pilot catchment feel confident accessing appropriate local health and social services/ programs?	▪ Level of student and parent awareness of local health and human services ▪ Level of student and parent confidence in accessing local health and social services ▪ Number of students and parents who access local health and social services (approximate if quantitative data is not available)	▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders ▪ Administrative and clinical data	Short-term outcomes
Student (and family) health and wellbeing needs are identified *(Indirect measure of program success)*	▪ To what extent has the pilot contributed to student health and wellbeing needs being identified?	▪ Local service provider, school management and young people's perceptions identification timing pre- and post-pilot commencement ▪ Deidentified, aggregate clinical service data	▪ Interviews with school management ▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders ▪ Administrative and clinical data	Short-term outcomes

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
The Model has been successfully incorporated into a whole-of-school approach to student wellbeing (as available) *(Indirect measure of program success)*	▪ To what extent have schools in the pilot catchment incorporated the Model into a whole-of-school approach to student wellbeing	▪ School management and frontline staff perceptions on the extent to which the pilot has been formally and informally linked to existing health and wellbeing activities	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff	Short-term outcomes
WHIN Coordinator provides opportunistic health education and promotion to school communities (one-on-one and group) *(Direct measure of program success)*	▪ What is the number and type of health education and promotion programs developed by WHIN Coordinators? ▪ What is the number and type of health education and promotion programs delivered by WHIN Coordinators? ▪ How many students/parents have participated in health education and promotion programs? ▪ To what extent have students and parents found the health education and promotion programs useful?	▪ Number and type of health education and promotion programs developed by WHIN Coordinators ▪ Number and type of health education and promotion programs delivered by WHIN Coordinators ▪ Number of students/parents who have participated in health education and promotion programs ▪ Parent and young person perceptions of program usefulness	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Administrative data	Outputs

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
Students (and families) triaged and connected with local service providers *(Direct measure of program success)*	▪ How many students and families within the pilot catchment have triaged the WHIN Coordinator (group and one-on-one)? ▪ What is the number and types of service provided by the WHIN Coordinator? ▪ To what extent are students and families satisfied with the services provided by the WHIN Coordinator? ▪ To what extent are students and young people within the pilot catchment being referred to appropriate health and human services?	▪ Number of students and families within the pilot catchment who have accessed the WHIN Coordinator ▪ Number and type of services provided by WHIN Coordinators ▪ Student and parent perceptions of service experience ▪ Number of young people and families referred to appropriate health or human services ▪ Amount of time between consultation with WHIN Coordinators and referral (approximate if quantitative data is not available)	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders ▪ Survey of all stakeholders ▪ Administrative and clinical data	Outputs
Students are referred to the WHIN Coordinator *(Direct measure of program success)*	▪ How optimal are the processes for being referred to the WHIN Coordinator? ▪ How many children (primary school) have been referred to the WHIN Coordinator? ▪ How many young people (high school) have been referred to the WHIN Coordinator?	▪ Young person, school management, and WHIN Coordinator perceptions on the referral process ▪ Number of children who have been referred to the WHIN Coordinators ▪ Number of young people who have been referred to the WHIN Coordinators	▪ Interviews with school management ▪ Interviews with WHIN Coordinators and frontline staff ▪ Focus groups with young people ▪ Interviews with other stakeholders (including parents) ▪ Interviews with community stakeholders ▪ Survey of all stakeholders ▪ Administrative and clinical data	Outputs

Expected outcomes	Evaluation questions	Indicators/evidence	Data sources	Outcomes hierarchy
Partnerships are developed between WHIN Coordinators and local schools and service providers *(Direct measure of program success)*	▪ To what extent do strong partnerships exist between the WHIN Coordinators and schools within the pilot catchment? ▪ To what extent do strong relationships exist between the WHIN Coordinators and local health and human services? ▪ What is the number and type of *formal partnerships* that exist between the WHIN Coordinator and local health and human services? ▪ What is the number and type of *informal partnerships* that exist between the WHIN Coordinator and local health and human services?	▪ School management and community stakeholder views on relationship with WHIN Coordinator ▪ Number and type of partnerships between WHIN Coordinators (individual and overall) and schools ▪ Number and type of *formal partnerships* that exist between the WHIN Coordinator and local health and human services? (approximate if quantitative data is not available) ▪ Number and type of *informal partnerships* that exist between the WHIN Coordinator and local health and human services (approximate if quantitative data is not available)	▪ Interviews with school management ▪ Interviews with frontline staff ▪ Administrative data ▪ Interviews with community stakeholders ▪ Survey of all stakeholders ▪ Administrative and clinical data	Outputs
Management and governance: Establish Steering Committee and governance arrangements; set out the collaborative relationship between NSW Health, Department of Education, and Department of Premier and Cabinet; set model of care and service delivery model(s); develop key performance indicators (KPIs) and mechanisms for reporting against KPIs (throughput, referral rates, and so on)		**Implementation:** Develop scope of practice for WHIN Coordinators; engage stakeholders and hire WHIN Coordinators; establish work environments and resources, establish occupational health and safety, and insurance arrangements, engage local stakeholders		
By Need				
Students are not accessing health and social services in rural areas due to socio-economic factors, access challenges, lack of knowledge about services, and fewer accessible service pathways. This contributes to the unmet health and social needs amongst students, which can impact on engagement in education.				

APPENDIX B REFERENCE LIST

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APPENDIX C SUMMARY OF AUSTRALIAN NURSES IN SCHOOLS PROGRAMS

State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
QLD	School Based Youth Health Service (SBYHS)	Partnership: Education QLD and QLD Health	The SBYHS provides state high school students with information and guidance on their healthcare needs and provide referrals to appropriate services when required. The SBYHS provides one-on-one health consultations with state high school students, providing them with advice and support on their health care needs. They also work with Education Queensland staff to assist students and their families with identified health concerns and refer them to the appropriate services.	The SBYHS has nurses based in QLD state high schools to work with young people, school staff and parents to promote health and wellbeing, create a supportive, healthy school environment, and connect people with other support services. Nurses provide students with one-on-one health consultations to provide information, assessment, support and referral options for health needs related to healthy eating, relationships, family problems, sexual health, smoking, AOD, growth and development, and feeling unhappy or stressed. Nurses do not provide medical treatments, first aid, medications, physical examinations, or ongoing counselling.	No	It is a voluntary confidential service for young people.	Parents or young people can self-refer, or a referral can be made by a health professional or school staff.
QLD	State Schools Nursing Service (SSNS)	Queensland Department of Education and Training	The SSNS provides support to QLD public school staff to manage the health care requirements of, or provide reasonable adjustments for, students with a disability or specialised health need.	The SSNS employs regionally based registered nurses who are available to state schools in QLD. Nurses work with students, family and school staff to support with risk assessments, develop daily healthcare routines, develop emergency school health plans and provide training to perform health procedures. The SSNS can support students with health needs including artificial feeding, urinary catheterisation, clear airway maintenance, oxygen therapy, stoma bag/device management, diabetes, epilepsy, anaphylaxis, and asthma.	Yes	Student and/or parental consent is required to access the service.	The SSNS is available for students who require a specific health procedure during school hours.

State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
ACT	School Youth Health Nurse Program (SYHNP)	ACT Health supported by ACT Education Directorate.	The SYHNP adopts a whole-of-school approach to promote positive health outcomes for young people through health promotion and early intervention, to support the transition to adulthood.	Nurses provide a first point of contact for health matters in school and offer referrals to appropriate health services. Youth health nurses provide individual health consultations for students, support school-based health promotion activities, run health promotion work groups, support teachers to deliver the health curriculum and provide consultations to families and the school community for information, advice and support. School Youth Health Nurses are employed by ACT Health to provide services in 7 ACT high schools	No	Information unavailable	No specific access or eligibility requirements mentioned.
ACT	Healthcare Access at School (HAAS)	ACT Health in collaboration with the Education Directorate	The HAAS program supports students with complex healthcare needs to attend ACT Government Schools	The HAAS program provides nurse-led care during school time and provides a link between parents and the school to ensure appropriate healthcare support for students. HAAS Nurses will develop a student care plan and train school-based staff (such as First Aid Officers or Learning Support Assistants) in the specific healthcare procedures required by the student. HAAS Nurses are Level 2 Registered Nurses that support school-based staff but are not based in schools.	Yes	Student care plan is developed in consultation with school staff and parents.	Students are typically referred to the program at school enrolment.

State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
VIC	Primary School Nursing Program (PSNP)	Victorian Department of Education	To respond to parental concerns about the health and wellbeing of their child and identify students with potential health related learning difficulties.	Nurses visit primary schools throughout the school year to administer health assessments to students in their first year of primary school. A School Entrant Health Questionnaire (SEHQ) is provided to parents to complete before the health assessment. Nurses also provide formal and informal health promotion, information and advice to children, families and the school community. Nurses will suggest referrals to an appropriate health care service for any concerns identified during a health assessment	No	Health assessments can only be administered with the consent of parents.	Available free to all primary school students.
VIC	Secondary School Nursing Program (SSNP)	Victorian Department of Education	To reduce young people's health risk and support health promotion and primary prevention in secondary schools.	Nurses conduct several activities in schools for health promotion and prevention including community development, small group work for health discussion, individual student health counselling, information, advice and referral. Nurses may also support teachers to deliver the health curriculum and health policies within the classroom. The program operates in 2/3 public high schools, targeted towards the most disadvantaged schools. The program employs 261 nurses (FTE 185) across NSW) Nurses are employed by regional education offices and are typically allocated to work in two schools.	No	It varies based on the activity.	No specific access or eligibility requirements mentioned.

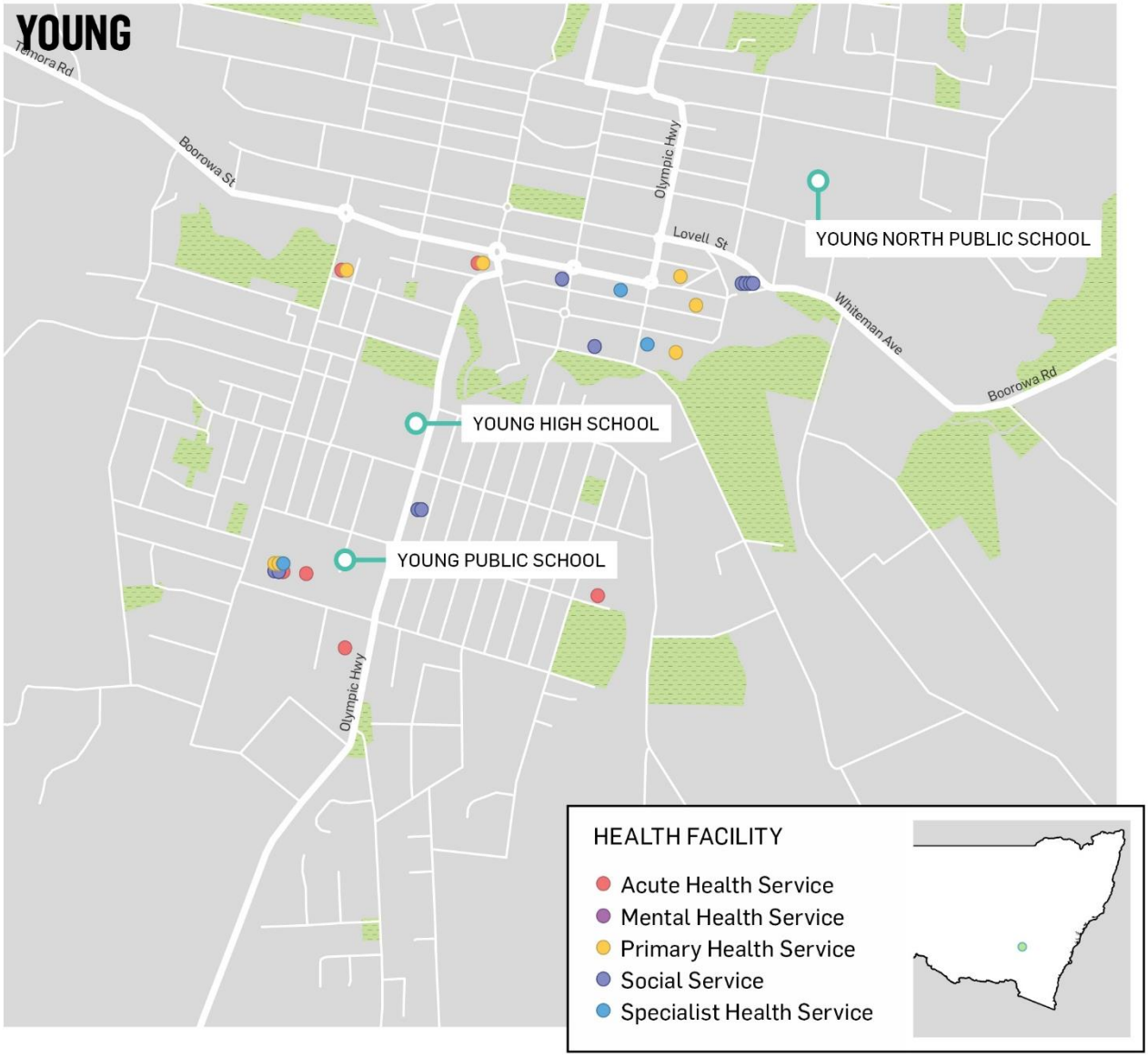
State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
TAS	School Health Nurse Program (SHNP)	Tasmanian Department of Education	To increase health education outcomes for Tasmanian students by supporting schools to develop physical and social environments that support student's health and wellbeing.	The SHNP works across both primary and secondary schools to collaborate with staff to provide health screening, assessments, promotion and education activities. In primary schools, nurses focus on vision and hearing screening, provide developmental assessments when required and deliver health promotion and education in line with the curriculum. In secondary schools, nurses focus on positive parenting for teenage parents, health promotion and education in line with the curriculum and targeted screening to address medical issues that may impact learning. The program has been rolled-out at targeted schools over 4 years (2014-2018), with funding committed to extend the program. In 2017 the program employed 25 nurses and covered 81 schools. Nurses are regionally based and are allocated to deliver services to several schools.	No	No information provided	No specific access or eligibility requirements mentioned.

State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
WA	School Health Service (SHS)	Partnership and joint funding: WA Department of Health and WA Department of Education.	To promote healthy development and wellbeing for students by providing community health nurses as a point-of-contact within schools.	The SHS team consists of community health nurses and other health professions. Nurses visit schools or may be based at larger secondary schools. The SHS provides a simple first point-of-contact for students about their healthcare. The SHS provides information and advice through health education sessions, health and wellbeing programs, and directly to students and families. Nurses conduct health assessments, develop care plans for students with specialised needs and provide referrals to other healthcare professions when required. The SHS offers a health assessment to all first-year primary school students. For adolescent students, the SHS provide information, advice, support and referrals for students and encourage them to take control of their personal health. The SHS provides guidance on issues such as coping with illness, culture and racism, anxiety or stress, healthy eating and body image, mental health, loss and grief, relationships, smoking, alcohol and drug use, and sexual health.	No	Primary student health assessments require parental consent. Information about adolescent students is shared with parents if necessary for the health and safety of the young person.	No specific access or eligibility requirements mentioned.

State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
NSW	Forbes High School Wellness Hub (FHSWH)	Forbes High School	To provide an inclusive framework to support the cognitive, emotional, social, physical and spiritual wellbeing of students by providing a safe place for students and their parents/carers to access free and confidential services.	The FHSWH provides onsite offices for community partners to offer services within the school environment. Partnerships have been formed with government and non-government service providers encompassing homelessness, health and mental health, parenting programs, and youth and family services. Partners are engaged to promote health seeking behaviour, information, referral and guidance, decision-making, and facilitation of productive social relationships. The FHSWH makes use of counsellors, youth workers, Aboriginal education workers, administration support and a Head Teacher for Wellbeing.	No	Services are confidential	Available free to students and parents/carers.
NSW	Student Health Coordinator (SHC)	Fairvale High School	Support student health and wellbeing needs.	A SHC is employed as part of the Welfare Hub to provide health and wellbeing assistance and first aid. The SHC is a registered nurse. The Welfare hub provides access to Speech Pathology, Occupational Therapy and Clinical Psychology services.	Yes	No information provided	No specific access or eligibility requirements mentioned.
NSW	School Based Nurses	Far West LHD	To promote healthy behaviours, enhance health literacy and prevent and reduce the risk and impact of poor health on children, young adults, and families.	A registered nurse is employed to identify and provide early intervention for health and social concerns, improve coordination and integration of health and social care services, and improve access to health and social care services for children, young people, and families. The school based nurse also delivers health promoting programs, maintain individual health plans, and implement complex and chronic disease management plans.	Assumed No	No information provided	No specific access or eligibility requirements mentioned.

State	Program Name	Responsible Agency	Program Aims	Program Description	Is this a clinical role?	Consent and Privacy	Access and Eligibility
NSW	School Health Program (Tweed Heads / Byron Bay)	Northern NSW LHD		The School Health Program is a targeted screening program in 16 schools in the Tweed/Kingscliff region and includes Before School Assessments and the Otitis Media (hearing) program. Community Health and School Health Nurses see children in relation to any aspect of a child's health. The Byron Bay program screens students in all schools and preschools, with priority given to Aboriginal students.	Assumed Yes	No information provided	Children are seen on a referral basis. Referrals are made by parents, teachers, or school counsellors.

APPENDIX D COMMUNITY PROFILES



ICSEA SCORE

932
Young High School

968
Young Public School

921
Young North Public School

Index of Community Socio-Educational Advantage (ICSEA), sourced from ACARA. The ICSEA is a scale that represents levels of educational advantage. ICSEA values are on a scale, which has a mean of 1000 and a standard deviation of 100. ICSEA values range from around 500 (representing extremely disadvantaged backgrounds) to about 1300 (representing schools with students from very advantaged backgrounds).

YOUNG
DEMOGRAPHICS

Evidence suggests that Young is an appropriate location for the WHIN Coordinator Model due to the significant proportion of the population under 20 years old, the percentage of family households, the level of social disadvantage in the region, and the higher prevalence of mental health concerns, suicide and self-harm, and obesity.

COUNTRY OF BIRTH

ABS 2016 Census

HOUSEHOLD COMPOSITION

ABS 2016 Census

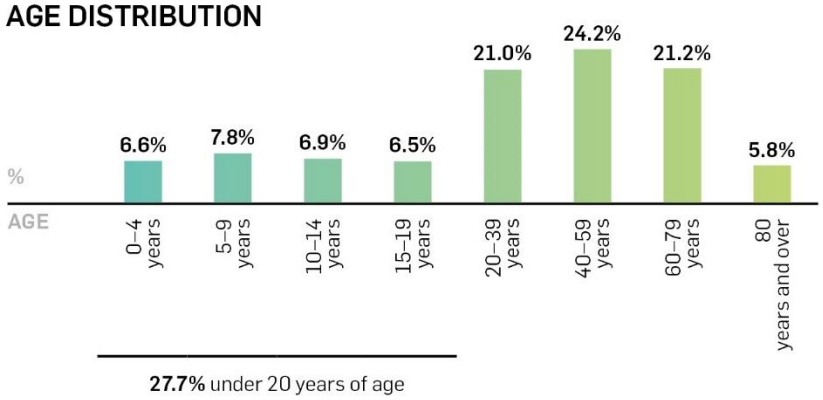
TOTAL POPULATION

10,603

ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLE

4.2%

AGE DISTRIBUTION



ABS 2016 Census

MEDIAN HOUSEHOLD WEEKLY INCOME

$967

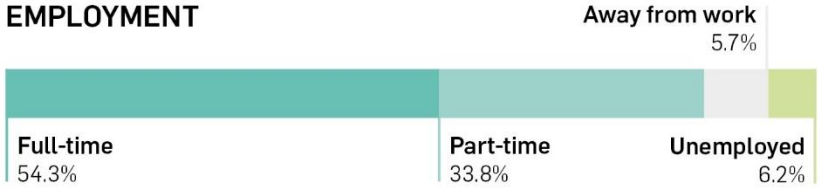
ABS 2016 Census

SOCIAL DISADVANTAGE

The ABS ranks **Young in the lowest quintile for relative socio-economic disadvantage** in Australia.

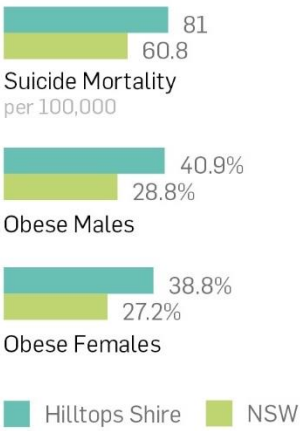
ABS 2016 Index of Relative Socio-economic Disadvantage

EMPLOYMENT



ABS 2016 Census

HIGH IMPACT HEALTH FACTORS



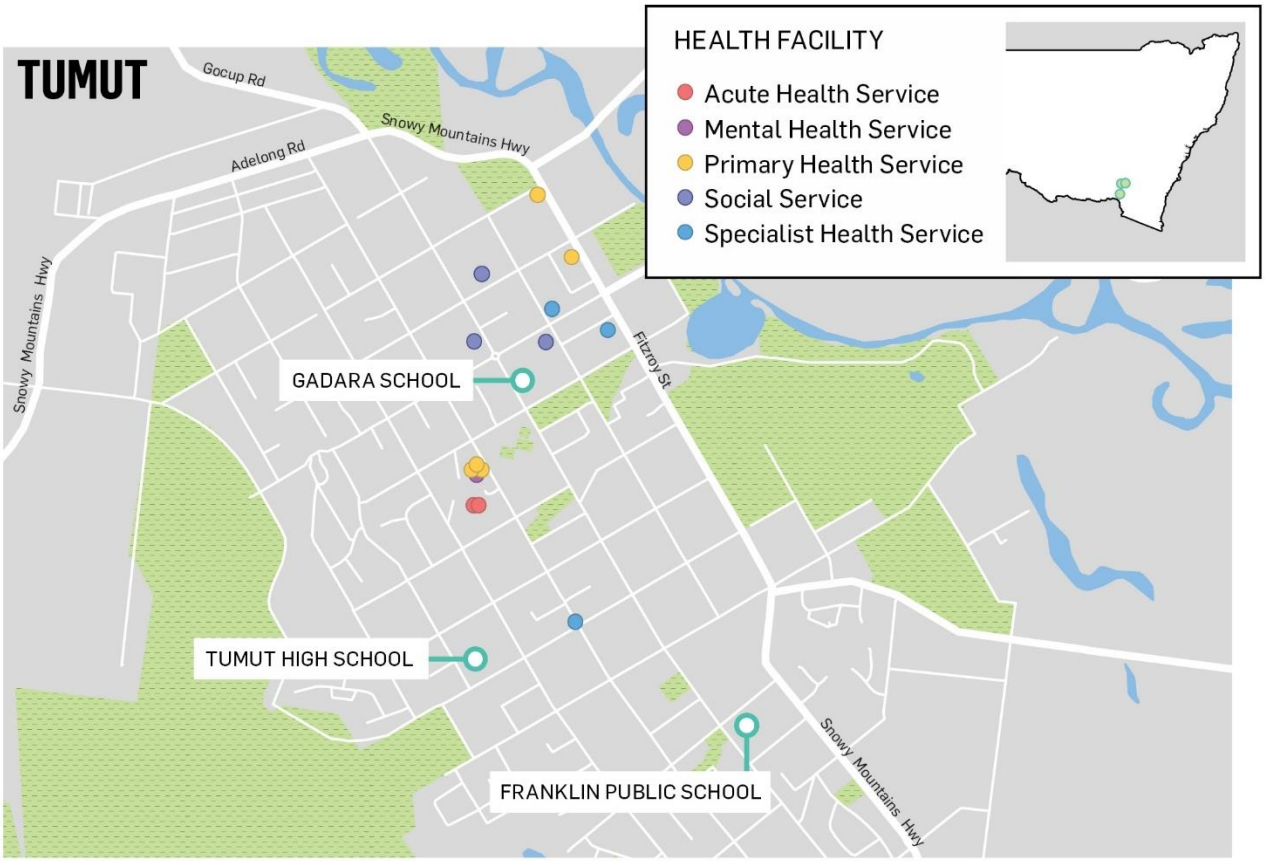
High rates of overweight and obesity in youths. 23% of teenaged children in the PHN are reported to be overweight and obese compared to the NSW state average (21%).

Mental health issues in young people in the PHN are higher than the state average. 50% of youth hospitalisations are attributed to mental health issues.

Hospitalisations for intentional self-harm in young people in the PHN are much higher than the NSW state average, particularly for young women in Cootamundra, Young, Tumut and Leeton

Murrumbidgee PHN 2017 Health Needs Assessment

Murrumbidgee PHN regional profile summary for Snowy Valleys Shire



ICSEA SCORE

951
Tumut High School

938
Tumbarumba High School

978
Tumut Public School

911
Franklin Public School

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TUMUT–TUMBARUMBA DEMOGRAPHICS

Evidence suggests that Tumut-Tumbarumba is an appropriate location for the WHIN Coordinator Model due to the significant proportion of the population under 20 years old, the percentage of family households, the level of social disadvantage in the region, and the higher prevalence of mental health concerns, suicide and self-harm, and obesity.

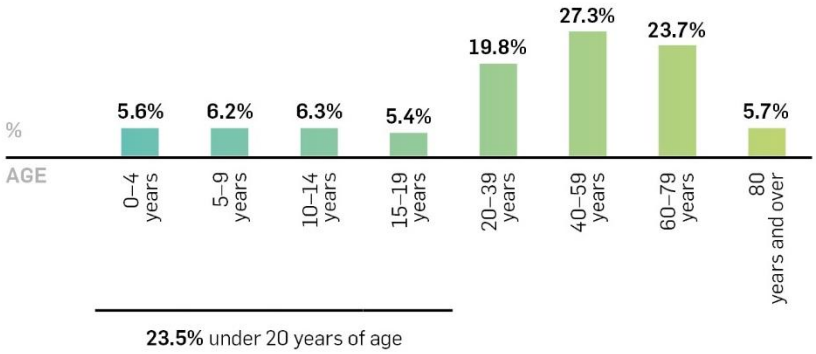
COUNTRY OF BIRTH

ABS 2016 Census

HOUSEHOLD COMPOSITION

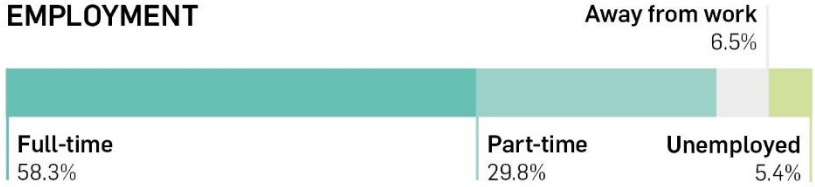
ABS 2016 Census

AGE DISTRIBUTION



ABS 2016 Census

EMPLOYMENT



ABS 2016 Census

High rates of overweight and obesity in youths. 23% of teenaged children in the PHN are reported to be overweight and obese compared to the NSW state average (21%).

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Murrumbidgee PHN 2017 Health Needs Assessment

Murrumbidgee PHN regional profile summary for Snowy Valleys Shire

TOTAL POPULATION

14,436

ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLE

4.4%

MEDIAN HOUSEHOLD WEEKLY INCOME

$1,120

ABS 2016 Census

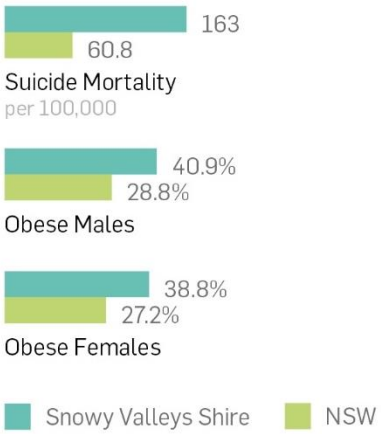
SOCIAL DISADVANTAGE

The ABS ranks **Tumbarumba in the second lowest quintile for relative socio-economic disadvantage** in Australia.

The ABS ranks **Tumut in the lowest quintile for relative socio-economic disadvantage** in Australia.

ABS 2016 Index of Relative Socio-economic Disadvantage

HIGH IMPACT HEALTH FACTORS



ICSEA SCORE

985
Monaro High School

978
Cooma Public School

972
Cooma North Public School

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COOMA
DEMOGRAPHICS

Evidence suggests that Cooma is an appropriate location for the WHIN Coordinator Model due to the significant proportion of the population under 20 years old, the percentage of family households, the level of social disadvantage in the region, and the higher prevalence of mental health concerns, high risk alcohol consumption, suicide and self-harm, and obesity.

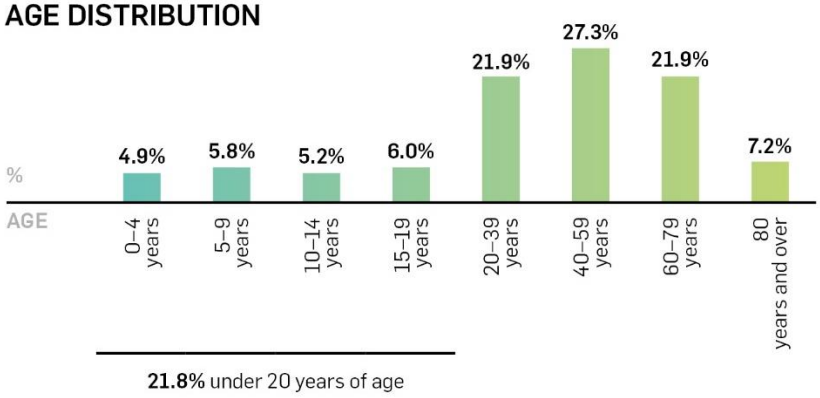
COUNTRY OF BIRTH

ABS 2016 Census

HOUSEHOLD COMPOSITION

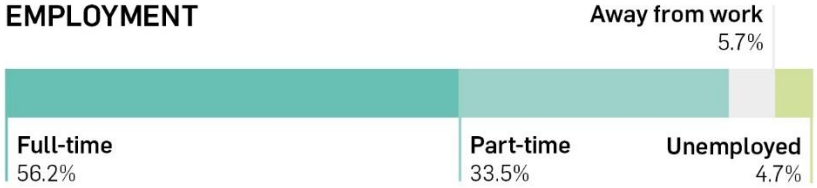
ABS 2016 Census

AGE DISTRIBUTION



ABS 2016 Census

EMPLOYMENT



ABS 2016 Census

Higher than NSW and Australian average estimates for **prevalence of long-term mental or behavioural problems and high or very high psychological distress.**

Higher than NSW and Australian rates for **suicide deaths and intentional self-harm related hospitalisations.**

Higher than NSW and Australian average prevalence figures for chronic conditions including **mental and behavioural disorders, respiratory conditions, circulatory system diseases and musculoskeletal conditions.**

Higher than NSW and Australian average prevalence figures for **high risk alcohol consumption and smoking.**

South Eastern NSW PHN 2018 Health Profile Infographic

South Eastern NSW PHN 2013 Population Health Monaro Sub-Regional Profile

TOTAL POPULATION

6,734

ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLE

3.2%

MEDIAN HOUSEHOLD WEEKLY INCOME

$1,120

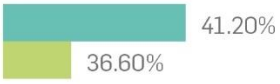
ABS 2016 Census

SOCIAL DISADVANTAGE

The ABS ranks **Cooma in the second lowest quintile for relative socio-economic disadvantage** in Australia.

ABS 2016 Index of Relative Socio-economic Disadvantage

HIGH IMPACT HEALTH FACTORS



Physically inactive persons

Monaro

Southern NSW Medicare Local

APPENDIX E WPMT DATA DICTIONARY

Domain	Data point	Definition	Available Options	Option definition
Primary Client Demographic Information	School ID Number	Unique student identifier	N/A	
	First Name	Given name of the primary client (student)		
	Last Name	Family name of the primary client (student)		
	Gender	Gender as recorded by NSW Health	Female	Primary client identifies as female
			Male	Primary client identifies as male
			Other	Primary client identifies as neither female nor male
	Aboriginality	Aboriginal status as recorded by NSW Health	Aboriginal	Primary client identifies as Aboriginal
			Torres Strait Islander	Primary client identifies as Torres Strait Islander
			Both Aboriginal and Torres Strait Islander	Primary client identifies as both Aboriginal and Torres Strait Islander
			Neither Aboriginal nor Torres Strait Islander	Primary client identifies as neither Aboriginal nor Torres Strait Islander
	Date of birth	Date of birth as recorded by NSW Health	N/A	
	Postcode	Postcode of the primary client as recorded by NSW Education		
	Current School	School at which the primary client is currently enrolled		
	Previous School	Schools where the primary client has been enrolled and has engaged with the WHIN Program		
	Grade	School grade in which the primary client is currently enrolled		
Referral Information	Subject of health concern	The person whose health concern is the primary driver of the referral	Primary Client	Individual who was referred to the WHIN
			Parent	Mother or father of the primary client.
			Grandparent	Grandmother or grandfather of the primary client
			Carer	Carer or legal guardian of the primary client who is not their parent or grandparent

Domain	Data point	Definition	Available Options	Option definition
			Sibling	Brother or sister of the primary client (including step-siblings and half-sibling)
			Other family member	A familial relation of the primary client who is not their parent, grandparent, guardian or sibling.
			Friend	Friend, acquaintance, or non-familial relation of the primary client
			Other	Any relationship to the primary client that does not fit another category.
	CHOC number of subject	CHOC number of the person whose health concern is the primary driver of the referral	N/A	
	Referral Source	Referral pathway into the WHIN service	Principal	The principal, or person undertaking the principal's responsibilities, of the school where the primary client is enrolled.
			Deputy Principal	The deputy principal, or person undertaking the deputy principal's responsibilities, of the school where the primary client is enrolled.
			Health and wellbeing team	A member of the health and wellbeing team at the school where the primary client is enrolled.
			School Counselling Service	An employee of the school counselling service at the school where the primary client is enrolled.
			Teaching school staff	A member of the teaching staff the school where the primary client is enrolled who is not captured by another option
			Non-teaching school staff	A member of the non-teaching staff the school where the primary client is enrolled who is not captured by another option
			Self	The primary client
			Parent	A parent, carer or legal guardian of the primary client
			Friend	Friend, acquaintance, or non-familial relation of the primary client

Domain	Data point	Definition	Available Options	Option definition
	Referral date	Date primary client was referred to WHIN service	N/A	
	First session	Date when primary client first engaged with the WHIN service for this referral.		
	Number of sessions	Cumulative total of number of engagements between primary client and WHIN for this referral.		
	Case Closed	Date when primary client is no longer being actively supported by the WHIN for this referral.		
Presenting Issue	Presenting Issue(s)	Concern(s) identified as the underlying reason for the referral, categorised by type.	Mental health symptom	Concern regarding the student's mental health and wellbeing
			Physical health symptom	Concern regarding the student's physical health and wellbeing
			Behavioural symptom	Concern regarding the student's behaviour in a school or other context
			Learning difficulty	Concern regarding the student's ability learn or developmental progress
			Sexual health	Concern or inquiry related to the sexual health of the student
			Social support	Non-health related wellbeing or social concern that is not captured by another category
			School attendance	Difficulty, inability, or unwillingness to attend school
			Personal safety	Substantiated or perceive threat to personal safety that is not considered bullying
			Bullying	Victim or perpetrator of bullying
			Family / peer relationships	Concern regarding a relationship (familial, peer, romantic, platonic) between the primary client and another individual, or between two individuals associated with the primary client.

Domain	Data point	Definition	Available Options	Option definition
			Other	Any issue that is not captured by any other category
	Notes / Comments	Qualitative and detailed notes to provide context to the presenting issue categories selected.	N/A	
Outward Referral Pathway	Primary Outward Referral Pathway	The main or most significant referral option	Primary care	Generalised intervention or service related to the treatment of non-admitted patients in the community. It can include general practice, allied health services, community health and community pharmacy
			Acute care	Intervention or service that provides active but short-term treatment for a severe injury or episode of illness, or an urgent medical condition.
			Chronic care	Intervention or service that provides active but long-term treatment for a severe injury or illness.
			Mental health care	Intervention or service that primarily aims to improve a patient's mental health
			Social service	Intervention or service to address social welfare concerns
			Drug and alcohol service	Intervention or service to address misuse of drugs or alcohol
			Internal referral (DoE)	Any service or intervention provided by the NSW Department of Education
			No referral required	Issue addressed by WHIN Intervention
			Group session coordinated by WHIN	Any additional intervention coordinated by the WHIN program
			Referral declined	Primary client declined to be referred or declined additional service provision
			No referral option available	No appropriate service available

Domain	Data point	Definition	Available Options	Option definition
	No referral option comment	The desired primary outward referral pathway that was unavailable.	Primary care	Generalised intervention or service related to the treatment of non-admitted patients in the community. It can include general practice, allied health services, community health and community pharmacy
			Acute care	Intervention or service that provides active but short-term treatment for a severe injury or episode of illness, or an urgent medical condition.
			Chronic care	Intervention or service that provides active but long-term treatment for a severe injury or illness.
			Mental health care	Intervention or service that primarily aims to improve a patient's mental health
			Social service	Intervention or service to address social welfare concerns
			Drug and alcohol service	Intervention or service to address misuse of drugs or alcohol
			Internal referral (DoE)	Any service or intervention provided by the NSW Department of Education
			Group session coordinated by WHIN	Any additional intervention coordinated by the WHIN program
	Service Type	Type of organisation who delivers the service or intervention of the primary outward referral pathway	Government	Intervention or program is delivered by a government-run service
			Non-government	Intervention or program is delivered by a non-government organisation
			Private	Intervention or program is delivered by a privately run service
	Delivery Mode	Method of delivery of the intervention	In-person	Service is delivered in-person by a provider based in the same location as the primary client.
			In-person (outreach)	Service is delivered in-person by a provider not based in the same location as the primary client.
			Telehealth	Service is delivered not in-person (i.e. via telephone, video conference, or online)

Domain	Data point	Definition	Available Options	Option definition
	Referral Accepted	Did the referral organisation agree to take on the primary client	N/A	
	Referral Actioned	Has the primary client attended the referral organisation?		
	Additional Outward Referral Pathways	Any secondary or supplementary outward referral options	Primary care	Generalised intervention or service related to the treatment of non-admitted patients in the community. It can include general practice, allied health services, community health and community pharmacy
			Acute care	Intervention or service that provides active but short-term treatment for a severe injury or episode of illness, or an urgent medical condition.
			Chronic care	Intervention or service that provides active but long-term treatment for a severe injury or illness.
			Mental health care	Intervention or service that primarily aims to improve a patient's mental health
			Social service	Intervention or service to address social welfare concerns
			Drug and alcohol service	Intervention or service to address misuse of drugs or alcohol
			Internal referral (DoE)	Any service or intervention provided by the NSW Department of Education
			Issue addressed by WHIN Intervention	Issue addressed by WHIN Intervention
			Group session coordinated by WHIN	Any additional intervention coordinated by the WHIN program
			N/A	No additional referral pathways identified
	Notes / Comments	Qualitative and detailed notes to provide context to the presenting issue categories selected.	N/A	

Domain	Data point	Definition	Available Options	Option definition
Optional Data - for WHIN Coordinator's use if relevant				
Family Relationships	Relationship Type	Additional patients/clients who are related to the primary client in a way that is relevant to this referral	Parent	Mother or father of the primary client.
			Grandparent	Grandmother or grandfather of the primary client
			Carer / guardian	Carer or legal guardian of the primary client who is not their parent or grandparent
			Sibling	Brother or sister of the primary client (including step-siblings and half-sibling)
			Other family member	A familial relation of the primary client who is not their parent, grandparent, guardian or sibling.
			Friend	Friend, acquaintance, or non-familial relation of the individual referred to the WHIN
			Other	Any relationship not captured by any other category
	CHOC Number	CHOC number of the person whose health concern is the primary driver of the referral	N/A	