

Mental Health and Wellbeing Strategy

Foreword

The foundations for lifelong mental health and wellbeing are built during childhood. Children with good mental health and wellbeing are more likely to reach their full potential, have fulfilling relationships, and be able to adapt to and cope with adverse circumstances. It is therefore essential that Australia has a National Strategy to provide a long-term vision for how we will support the mental health and wellbeing of all children. We know that prevention is more effective than treatment, and so investing in our children and their families is the most important investment we can make. Improving children's mental health and wellbeing will improve the whole mental health system.

The National Mental Health Commission (the Commission) has been tasked with developing this Strategy as part of the Australian Government's *Long-Term National Health Plan*. This Strategy is the first of its kind, with a focus on children from birth through to 12 years of age, as well as the families and communities that nurture them. The Strategy outlines the requirements for an effective system of care for children, and seeks to create a new, shared understanding of the roles of families, communities, services, and educators in promoting and supporting child mental health and wellbeing. It has been developed with invaluable input from a diverse range of children and young people, their parents and carers, and Aboriginal and Torres Strait Islander communities. We sought to consider the breadth of environments children live within, and have heard from those who are working with children and their families in educational settings, juvenile justice, the out-of-home care system, and the health system. We have also incorporated the insights of those working and living in rural and remote communities, and have included actions in the Strategy intended to increase supports available to them.

This Strategy is delivered to Government amidst a complex environment of reviews and reform. When developing the Strategy, we have considered the recommendations of the Productivity Commission's inquiry report on the social and economic benefits of investing in mental health. We also note the considerable work being completed to revise and refresh the *National Framework for Protecting Australia's Children 2009-2020*, and the priority areas and actions in the *National Action Plan for Children and Young People*. The Strategy has also been developed in parallel with the Commission's work on *Vision 2030*, a blueprint for a unified system of mental health and suicide prevention. Vision 2030 takes a whole-of-community, whole-of-life and person-centred approach to mental health; an approach which is echoed in the principles underpinning this Strategy.

We are now pleased to share this Strategy with the wider community, and look forward to monitoring Australia's progress towards building a system that supports the mental health and wellbeing of all children and families.

Christine Morgan, CEO, Commissioner

Lucy Brogden, Chair, Commissioner

A message from the co-Chairs

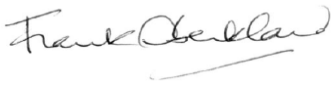
Despite the best efforts of governments over the years, providing timely, appropriate and equitable access to services supporting child mental health has been problematic. Mental health services are delivered in many settings by a range of providers, with poorly developed linkages between them. In particular, the referral pathways between primary health care and educational settings and secondary and tertiary assessment and treatment services are often unclear; services tend to be delivered in narrow, single-discipline clinics despite many children having complex needs and requiring a multidisciplinary approach; parents as well as many professionals have difficulty navigating a fragmented service system; and there are long waiting lists for assessment and treatment for all but the most severe problems.

There is increasing recognition of the importance of considered investment in child mental health. The service system needs to respond better to increases in the prevalence of mental health problems in Australian children, compounded by the effects of the COVID-19 pandemic. Furthermore, increased attention is paid to the need for child mental health services to be both effective and cost efficient. There are many opportunities for prevention and early intervention as problems start to emerge, and before they become entrenched and need more intensive treatment.

We accepted the appointment to co-Chair this Strategy with some trepidation due to the size of the challenge, but were excited to be given the opportunity to be involved in the development of a roadmap that might guide future reform and investment. We were interested in looking broadly at the system as a whole, from parent mental health literacy and reducing stigma through to the management of complex problems in expert settings and everything in between. Given the complexity of the current system, we did not want to argue for new services to be added. Rather, we aimed to develop a roadmap to effectively restructure and improve what was already in place and to support the many thousands of committed professionals working in this area. We are aware that a major restructure is more difficult than adding new services, but are convinced that this is the best way forward.

From the outset, we were committed to consultation with stakeholder groups – professional organisations and individuals – and to seek expert advice from different disciplines. We were able to meet with a wide range of stakeholder groups and gained valuable insights into what they perceived as strengths and weaknesses of the current system and, importantly, advice as to how to improve it. Many of their suggestions are reflected in the articulation of the issues and recommendations in the Strategy.

We were well-served by an expert advisory group and two working groups, where robust discussion and feedback helped shape our views and informed many aspects of the Strategy. Similarly, a steering committee guided our deliberations and provided valuable feedback and advice. And having this work sit within the National Mental Health Commission allowed us to draw on an incredible depth of content, organisational capacity, and outstanding writing skills, and we are most grateful to the staff and Commissioners for their wise counsel and support. We are well aware that this Strategy is only the first step in reform of mental health services for children and their families, and we hope that this provides a good foundation for implementing the urgently needed changes.





Professor Frank Oberklaid

Professor Christel Middledorp

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Executive Summary

The National Children's Mental Health and Wellbeing Strategy (the Strategy) provides a framework to guide critical investment in the mental health and wellbeing of children and families. There is nothing that will have more impact on improved mental health outcomes for all Australians than early intervention. Investing in the wellbeing of children and their families will have radiating benefits throughout our communities as well as through the broader health and education systems.

The Strategy provides clear pathways for proactively promoting child wellbeing and helping those who are struggling as early as possible to reduce long-term impacts of poor mental health. The Strategy adopts a broad scope to consider all settings in which children should be supported.

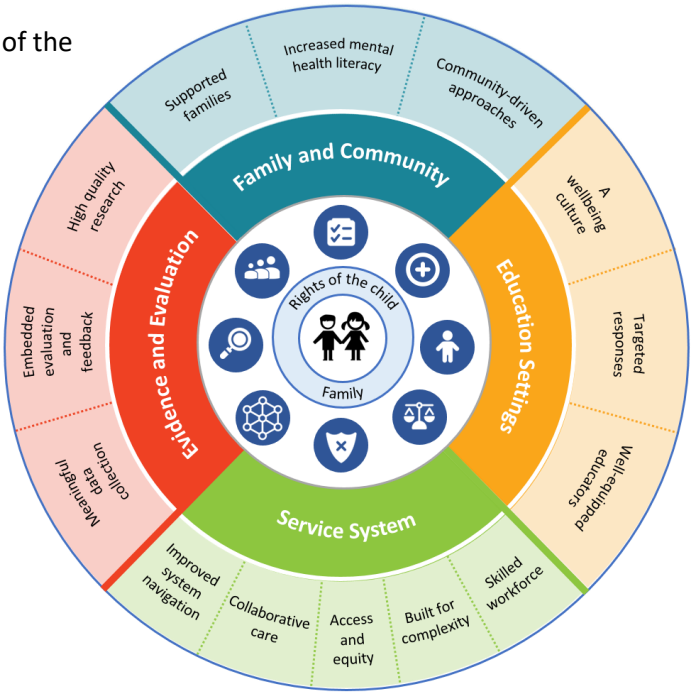
Eight principles have been used as the foundation of the Strategy's development.



These principles underlie the four **focus areas** of the Strategy.

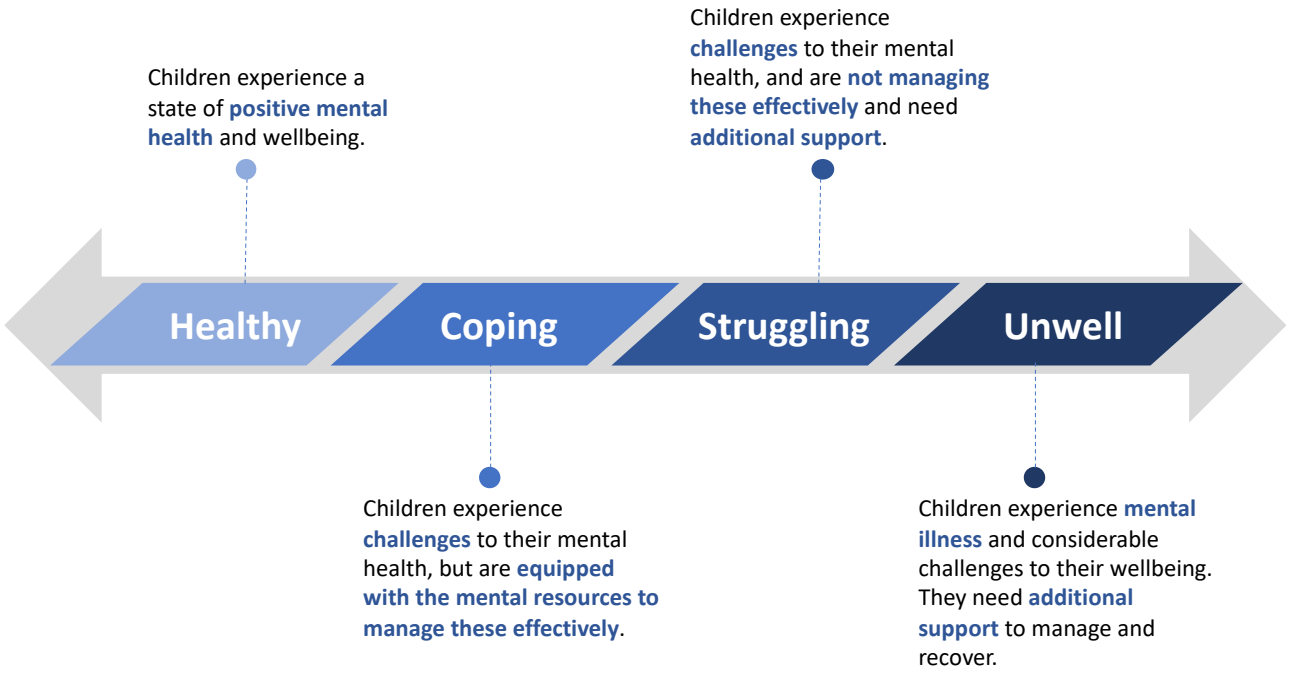
1. **Family and community**
2. **The service system**
3. **Education settings**
4. **Evidence and evaluation**

Each focus area contains **key objectives** that need to be achieved, and each objective has multiple associated **actions** that are required to **realise an optimal child mental health and wellbeing system.**



A wellbeing continuum

Importantly, beyond individual objectives and focus areas, the Strategy proposes a **fundamental, cultural shift in the way we think about the mental health and wellbeing of children**. This shift includes a change in language, adopting a continuum-based model of mental health and wellbeing. This moves away from terminology that may be stigmatising or too narrow to capture the full range of a child's emotional experiences.



The continuum approach highlights that there are opportunities to promote improved wellbeing and possibly intervene before a child becomes unwell. It also focuses on a child's **functioning rather than diagnosis**. For example, a child may have a diagnosed mental illness, but function well socially and educationally (i.e. 'coping'). Similarly, a child who is 'struggling' might not require a diagnosis, but would be experiencing a decline in their usual functioning or anticipated developmental trajectory.

The optimal mental health system includes universal services and programs that help children remain in, or move to, the healthy end of the continuum. In addition, it would provide targeted supports and services for children who are struggling or unwell. The Strategy proposes that children should be able to access funded services at the point that they are beginning to struggle, rather than only once they are unwell and have received a diagnosis.

Consultations also found that this continuum approach aligns well with Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, which focus less on mental illness and more on holistic approaches to supporting wellbeing.

Objectives of the Strategy

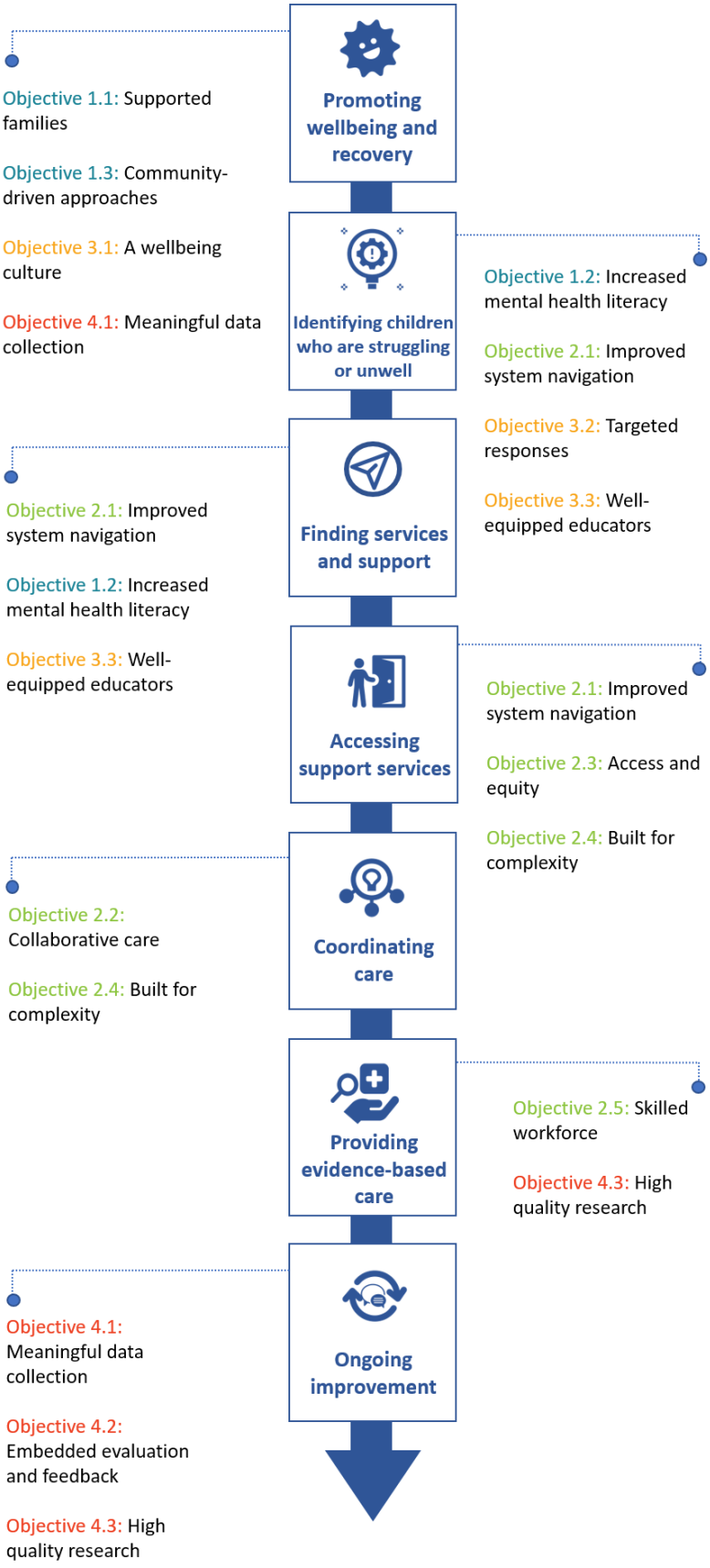
The objectives in the Strategy collectively span all aspects of a child's experiences of mental health, from promoting wellbeing and identifying children who are struggling through to providing evidence-based care and feedback and evaluation.

The figure on the right provides an overview of all objectives included in the Strategy. The objectives span across the focus areas and are numbered according to which focus area they align with, not in order of priority.

1. **Family and community**
2. **The service system**
3. **Education settings**
4. **Evidence and evaluation**

The following pages provide a snapshot of **key content and priority actions** across the four focus areas. These focus areas are equally important and their order in this Strategy does not imply priority or implementation sequence.

The focus area chapters provide additional depth beyond what is included in these one page snapshots. This includes existing approaches and tools we can build on, and indicators of change which may be used to monitor progress.





The Strategy highlights the importance of **empowering families** to promote mental health and wellbeing as part of routine parenting, and to actively collaborate with services when required. The importance of **community-based approaches** to health are also emphasised.

Objective 1.1 Supported families

- Support for families should begin with addressing risk factors and challenges in the perinatal period.
- Identifying parents who may be struggling is an effective strategy in promoting the wellbeing of their child.
- Parenting programs should be promoted to all families at key developmental stages as a way of supporting child development.
- Universal supports, such as parent helplines and antenatal courses, should also be promoted.
- Children not engaging with early childhood learning or primary school warrant systematic and proactive support.

Objective 1.2 Increased mental health literacy

- Parents and carers may not recognise the signs of poor mental health in their child.
- Signs that children are struggling can look different depending on developmental stage and may be impacted by culture and language background.
- Increasing mental health literacy and reducing stigma must be supported by the whole community.

Objective 1.3 Community-driven approaches

- Social and geographical environments have significant impacts on mental health and wellbeing.
- For children experiencing significant social and economic disadvantage, the needs of the broader community should be addressed to improve the mental health and wellbeing of the child.
- Strong and supportive relationships both inside and outside the home can have a protective effect on mental health and wellbeing.

Priority actions

Increase parent and carer mental health literacy and their skills to support child mental health and wellbeing, via:

- Routine offering of evidence-based parenting programs at key developmental milestones (action 1.1.c)
- Emotional wellbeing modules embedded in antenatal and parenting courses (action 1.1.f)
- Widely accessible evidence-based resources building on existing initiatives (action 1.1.b)
- A national campaign promoting the value of parenting programs (action 1.1.d).

Support communities with the highest levels of need to address social and economic disadvantage (action 1.3.a) through:

- Implementation of tailored programs focused on improving children's mental health and wellbeing based on the key characteristics of successful place-based approaches (action 1.3.b).

> ***"Think of [mental health and wellbeing] beyond the individual child or young person… that broader connection to how the family's travelling but also community in general."***
>
> **Professional working with migrant and refugee services**

> ***"To pull out each different part of our family's needs doesn't help us…we come as a unit, our needs are holistic."***
>
> **Parent / carer**

Executive Summary – Focus area 2: the Service System



The Strategy recognises that the current mental health service system is in need of great **reform**.

Objective 2.1 Improved system navigation

- A lack of clear, consistent information about where to seek help delays access to services and creates additional stress and burden for families.
- Existing navigational tools should be expanded to assist families to find local supports.
- A model of integrated family care should be established and networked across Australia.

Objective 2.2 Collaborative care

- Collaborative care is a model that relies on multiple service providers and family communicating about what a child needs.
- Increases in collaborative care approaches are required to ensure everyone understands what they need to do to support the child. This must include parents and carers.

Objective 2.3 Access and equity

- Many families are unable to access timely treatment, including due to high out-of-pocket costs, long waiting lists, dependency on diagnosis for treatment or high severity thresholds.
- Resourcing, training and integration of face-to-face and telehealth approaches must be increased to improve access to supports.

Objective 2.4 Built for complexity

- Children with complex needs are more likely to be turned away from support, as providers may not have the skills or resources required.
- Priority access should be given to at-risk cohorts, including children in State care or in contact with the justice system.
- Aboriginal Community Controlled Organisations should deliver supports for Aboriginal and Torres Strait Islander communities wherever possible.

Objective 2.5 Skilled workforce

- Increased incentives for training in child and family mental health are required to encourage increased workforce participation, including in regional and remote areas.

Priority actions

Improve the capacity of systems to deal with complexity through:

- Trialling (networked) sites in both urban and rural areas of a service model of integrated child and family care that exclusively provides holistic assessment and treatment for children 0-12 years old and their families (action 2.1.c)
- Trialling sites with innovative service delivery models that integrate face-to-face and telehealth consultations, digital interventions, and phone helplines (action 2.3.c)
- Providing support based on genuine co-design with children and families involved in the design, delivery and evaluation of services (action 2.3.e)
- Allocating specific funding for care co-ordination for children and families with complex needs (action 2.4.a)
- Requiring all government departments to outline and regularly report on what they do to support children in State care (action 2.4.c), including providing priority access to relevant services (action 2.4.b).

Amend current Medicare items to promote collaborative care including:

- Enabling all providers (regardless of discipline) to claim for case conferencing (action 2.2.a)
- Enabling providers to claim for consultations with parents and carers (without the child present) as part of the child's care (action 2.2.b)
- Requiring providers to communicate with educators and other service providers about a child's treatment and support plan (action 2.2.c).

"It was a wonderful moment when the psychologist asked [my son] if it would be ok to include Mum and Dad in part of the conversation… we were able to give context to the psychologist… I felt including us was really important and seems to have been really effective."

Parent / carer



The Strategy emphasises the important role that educational settings play in promoting mental health and wellbeing in children, and discusses the additional supports that may be required for educators to continue to build positive wellbeing cultures.

Objective 3.1 A wellbeing culture

- There is currently wide variation between schools and early childhood learning services in the culture around mental health.
- Some education settings have policies and procedures that contribute to stigma.
- Introducing dedicated wellbeing staff and proactively promoting resources and support in education settings will assist educators to build positive wellbeing cultures.
- Wellbeing programs should be included in early childhood curriculums and offered through after school and school holiday activities.

Objective 3.2 Targeted responses

- All early childhood learning services and schools should have a wellbeing plan in place, tailored to meet the needs of their students.
- Additional guidance is required to enable educators to discuss mental health concerns with parents and carers.
- Proactive outreach procedures should be developed to respond to student disengagement, using trauma informed approaches.

Objective 3.3 Well-equipped educators

- Professional training and clear guidelines and processes should be developed for educators to follow when they believe a child or family is struggling.
- Dedicated wellbeing staff should establish and maintain strong relationships with local service providers such as paediatricians and psychologists, to promote collaborative care.
- Educators should be supported to undertake additional learning on mental health, including with paid protected time for participation.
- All educators should have access to avenues for support for their own mental health and wellbeing.

Priority actions

Ensure educators are well-equipped to support child mental health and wellbeing by:

- Requiring all early childhood learning services and primary schools to have a comprehensive wellbeing plan for their students (action 3.2.a)
- Providing funding to implement quality improvement activities and delivery of evidence-based programs targeting needs identified in wellbeing plans (action 3.2.b)
- Having a designated wellbeing staff member in all early childhood learning services and primary schools who is responsible for planning and co-ordinating wellbeing activities, including the development of wellbeing plans (action 3.3.c).

> ***"One of the biggest challenges that schools are facing is the mental health of children… there is no national model of school counselling services… it's a murky water in terms of expectations, what really is the schools role in providing mental health support."***
>
> **Educator**

> ***"[The school] does lots of discussion around mental health to the point where it's quite ok for the girls to talk about it amongst their friends… when we were at school it would have been the ultimate shame to say 'I'm seeing a counsellor.'"***
>
> **Parent / carer**

The Strategy speaks to the importance of embedding a culture of evaluation in order to enable an optimal system of programs and services which provides consistently high quality supports for children and families.

Objective 4.1 Meaningful data collection

- Children's mental health is an area where key population data are missing[3] and there is currently no regular national data collection or reporting regarding children's overall mental health and wellbeing.
- A lack of data sovereignty means that programs or policies fail to reflect Aboriginal and Torres Strait Islander priorities, values, cultures, worldviews and diversity.[154]
- Increased and diversified data collection needs to be undertaken to inform delivery of programs and services.

Objective 4.2 Embedded evaluation and feedback

- There is a growing number of clinical services and programs targeted at children's and families' emotional wellbeing.
- Only a small number of programs have robust evaluation embedded into program design. Service providers should be required to build evaluation into their programs.
- Those using services have a valuable and essential perspective for informing service delivery.
- Evaluations are most useful when they focus on the key outcomes that are important and meaningful to the children and families who have used a service.

Objective 4.3 High quality research

- Unlike youth mental health, [168, 169, 170] there have been no national reforms or a framework for research focussed on children in Australia. There is also an overall lack of community consultation and trials in child mental health.
- Current ethics processes often make research with children challenging. Concerns around the vulnerability of children as a cohort could be better managed through including children and families in the development of research.
- In the optimal system, children would receive measurement-based care with treatment improved based on ongoing feedback.

Priority actions

Ensure better collection and use of data through:

- Establishing Inter-Departmental Committees to resolve current barriers to relevant data sharing across sectors such as education, justice and community health, for the purposes of informing child mental health and wellbeing (action 4.1.d)
- Embedding evaluation in program and service delivery from the beginning, with reporting of findings required to receive further funding (action 4.2.a)
- Including implementation evaluation as a core component of programs delivered in schools and early childhood learning settings (action 4.2.b) to identify what is required to ensure fidelity (action 4.2.c).

Require supports to be based on and continue to involve high quality research and evaluation through:

- Funding parity for child mental health research and child physical health (action 4.3.a)
- Targeted funding allocated on the basis of priorities including gaps in current treatment knowledge and the needs of children and families who are most vulnerable to mental illness (action 4.3.b).

> ***"What is the feedback and how are services flexible and responsive to adapt to what a particular community or subgroups within a community need in terms of mental health… it changes overtime as communities develop or new communities come."***
>
> **Professional working with migrant and refugee services**

1. Introduction

The imperative for promoting the wellbeing of children and preventing mental illness[1] is clear from a moral, social, and economic perspective.

Until now, Australia has not had a national strategy to guide action for supporting children's mental health[2] and wellbeing[3]. We currently have a mental health system that focuses on specialist intervention rather than prevention and early intervention, and on adults and adolescents rather than children. In fact, **for children under 12 years of age, there is no real 'system' of affordable, integrated care, delivered on the basis of need**.[1] Instead, there is a fragmented assortment of programs, service offerings, inconsistent sources of resources (that are not necessarily evidence-based), siloed professionals in private practice, alongside inequity in access due to a family's geographical and financial circumstances.

This Strategy aims to address these issues by mapping the minimum requirements for an effective system of care for children. It also aims to **move the language of child mental health and wellbeing away from a narrow view of pathology and diagnostic categories towards a continuum**. This is mirrored in the need to move towards needs-based access to services and to ensure equity in all systems. Finally, this Strategy aim to create a new, shared understanding of the roles of families, communities, services, and educators in promoting and supporting child mental health and wellbeing.

A particular characteristic of working with children and families is that services providers come from a range of sectors including health, education, family services, and NGOs; and from across jurisdictional contexts, including local government (immunisation, maternal and child health), state (clinical mental health, educational supports) and federal (childcare, primary care). **The onus to navigating these complexities should not sit with the child and their family**. This Strategy seeks to provide some guidance on what is required to simplify the experience of connecting with supports when they are needed.

Good mental wellbeing means that children are able to feel safe, happy, and supported, and have meaningful, loving connections with family, friends, and community. The **importance of family and community is emphasised throughout this Strategy** due to the central role that parents and carers[4]

[1] A **mental illness** is a disorder diagnosed by a health professional that significantly interferes with a person's cognitive, emotional and/or social abilities. Mental illness can vary in both severity and duration. The term mental illness is used to refer to a wide spectrum of diagnosable conditions that affect how a person feels, thinks, behaves, and interacts with other people.

[2] **Mental health** is a positive concept and more than just the absence of illness. In this Strategy, the term mental health is used to refer to a state of wellbeing where a person can realise their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to their community. Most infants and children experience good mental health. They are able to meet challenges, express a range of emotions in response to experiences, regulate those emotions, explore their environment, and form secure relationships, within the context of their developmental stage and their age.

[3] Good mental **wellbeing** means that children are able to feel safe, happy, and supported, and have meaningful, loving connections with family, friends, and community. A child who is well in this way is curious and interested in the world, they want to learn and can sit and reflect. They enjoy loving relationships and are able to bring themselves back from feeling upset when something doesn't go how they'd have liked.

[4] **A parent or carer** may be a child's biological parent, grandparent, step-parent, aunt or uncle, foster parent, adoptive parent, and any other person who performs a significant portion of the parenting and caregiving for the child. A parent or carer may not necessarily live with the child full-time. *Note:* The term carer is commonly used to refer to someone who provides ongoing personal care, support, advocacy and/or assistance to a person with mental illness. However, in this

play in the lives of children. A secure relationship with at least one primary caregiver is required for a child's sense of belonging and their healthy social and emotional development, and so we adopt a broad definition of family[5] that recognises that all families are different and a range of people can care for and support a child.

While families are central to optimal child development, **many families are subject to structural disadvantage**. This is a consequence of social and economic policies that fail to adequately address unemployment, poverty, educational attainment, racism and discrimination, and limit access to healthcare and other financial and social supports. This disadvantage may be further exacerbated by geographical location and by intergenerational trauma as a consequence of domestic and family violence, forced migration, or forcible removal of children from their family and culture of origin. In building this Strategy (section 1.2), we have sought to include the views of communities that face such disadvantage.

The Strategy also **takes into account the broader contexts where children live, learn, play, and grow**, and that not all children are equal in this regard. The proposed actions are designed to promote wellbeing and resilience at the family and community level, ensure effective supports are accessible for both parents and children who are struggling, and facilitate recovery when children or family are unwell.

1.1 Why this Strategy is so important

This National Strategy is critical because **mental health struggles often begin during childhood**. An estimated 50% of adult mental illness begins before 14 years of age.[2] In 2015, anxiety, depressive disorders and conduct disorders accounted for three of the five leading causes of disease burden for children aged 5-14 years.[3] Furthermore, there is evidence that poor mental health during childhood can lead to long term struggles. One study found that 50% of children with mental illness continue to struggle in adulthood; while the other 50% no longer warranted a diagnosis, their chance of functioning well was still less than that of people without a history of mental illness during childhood.[4]

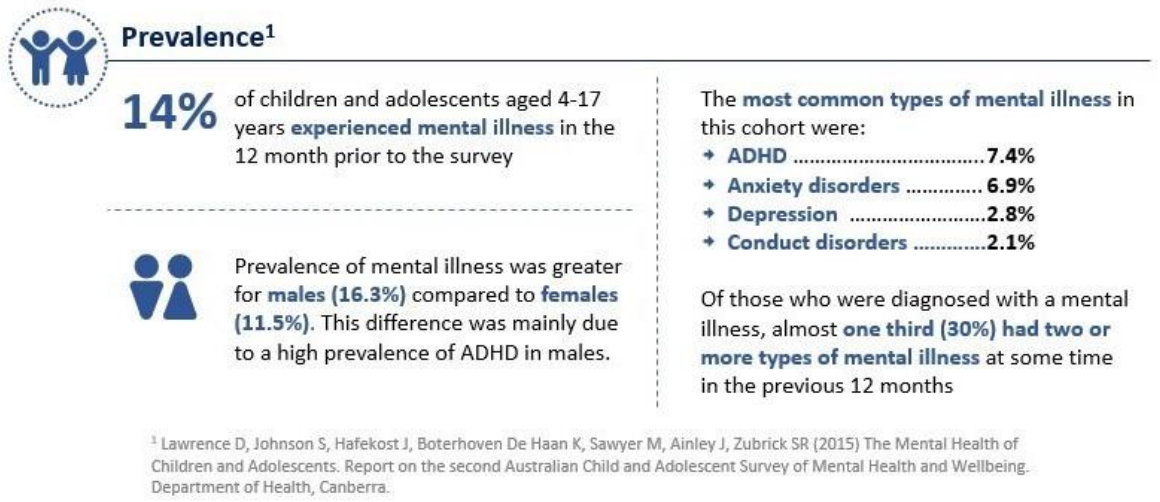
It is **relatively common for children to experience or be at risk of experiencing poor mental health**. Estimates indicate that 8% of infants (0–1 years) have 5 or more risk factors for developing mental illness, increasing to 20% of 10-11-year-olds.[5] While genetic factors contribute to mental illness,[6] there are strong links between adverse childhood experiences (ACEs) and development of mental illness.[7] Such experiences typically include violence, neglect, and other kinds of household dysfunction, including alcohol and substance abuse or parental separation and divorce. Exposure to ACEs is common, and they tend to cluster within families, but **there are clear actions that can be taken** to mitigate them, both by mental health professionals and through action in other domains outside of health care.[8]

Strategy, when used in the context of 'parent or carer', carer refers to anyone with a caring role for a child, regardless of whether the child experiences mental illness.

[5] The Strategy assumes that for every child, one or more adults adopts the role of parent or carer, forming a core component of a child's **family**. In addition to parents and carers, a child's family may also consist of other family members, such as siblings or grandparents, who may have a significant role in a child's life.

The **economic value of supporting mental health during childhood has also been demonstrated** – it costs significantly more to treat mental illness in adolescence and adulthood than it does to promote mental health and, if needed, intervene early during childhood.[9] Economic evaluations of early childhood development programs have repeatedly shown that the benefits exceed the costs.[10,11,12] This has been demonstrated in the United Kingdom, with school-based social and emotional learning programmes to prevent conduct disorders in the UK demonstrating cost savings of £150,000 for severe problems and £75,000 for mild problems (for each case prevented).[13] Similarly, one Australian report found that the return on investment of parenting programs for the prevention of childhood anxiety disorders was $2.40 for every $1 invested.[14]

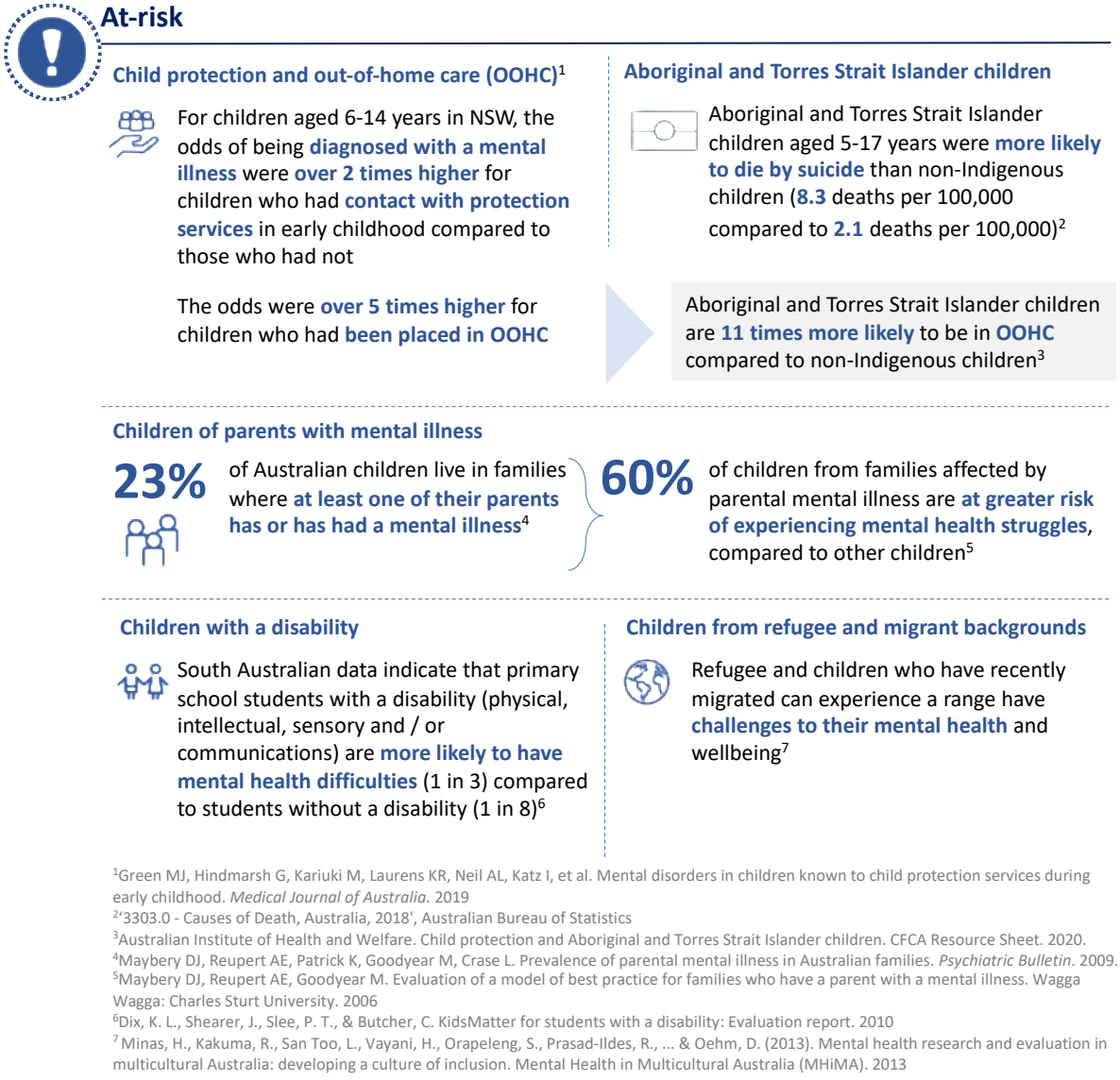
Not only is this Strategy critically important, but it's critically needed now. Many **experts have described Australia's current child mental health system as "broken"**.[15] While there is currently no regular national system for monitoring and reporting on the overall mental health and wellbeing of children 0-12 years old,[3] there are a small number of data sources to assist our understanding of the current landscape. Data from the Australian Child and Adolescent Survey of Mental Health and Wellbeing indicates that one in seven Australian children age 4-17 years' experience mental illness (see below).[16]



The above figures refer to Australian children generally. **Some cohorts of children are known to be at increased risk** of experiencing mental illness, including:

- **Children who have experienced the child protection and out-of-home care system.** This may be as a result of exposure to trauma prior to involvement with child protection services, as well as ongoing stress while in the care system.
- **Aboriginal and Torres Strait Islander children.** The wellbeing of Aboriginal and Torres Strait Islander populations continues to be compromised by intergenerational trauma, including from experiences of the Stolen Generations, disempowerment, and cycles of disadvantage.[17]
- **Children of parents with mental illness or parents with substance use.** Parental mental illness can place families at a greater risk of experiencing physical, emotional, and financial problems.[18] Families with parental substance misuse have higher rates of neglect, which is a major factor in a child being brought into care.[19,20]

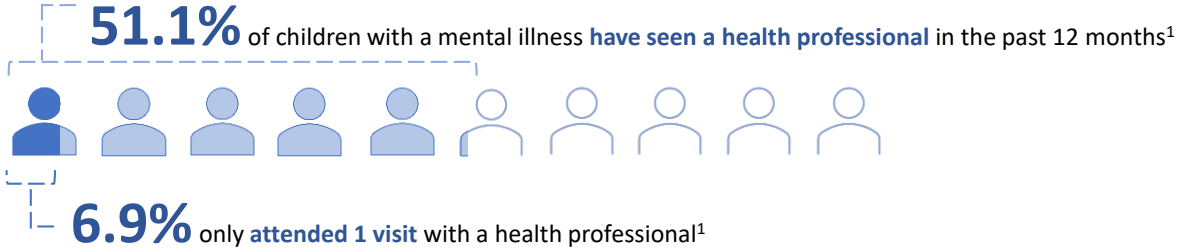
- **Children with disability or chronic illness.** Children with a disability or a chronic illness are at significantly higher risk of having mental health issues.[21,22]
- **Refugees and children who have recently migrated.** The migration experience can negatively impact child mental health and wellbeing, given the higher likelihood of exposure to trauma and stress of adapting to new culture and language, and in some cases with uncertain legal status and fear of deportation.[23]



[1]Green MJ, Hindmarsh G, Kariuki M, Laurens KR, Neil AL, Katz I, et al. Mental disorders in children known to child protection services during early childhood. *Medical Journal of Australia*. 2019
[2]'3303.0 - Causes of Death, Australia, 2018', Australian Bureau of Statistics
[3]Australian Institute of Health and Welfare. Child protection and Aboriginal and Torres Strait Islander children. CFCA Resource Sheet. 2020.
[4]Maybery DJ, Reupert AE, Patrick K, Goodyear M, Crase L. Prevalence of parental mental illness in Australian families. *Psychiatric Bulletin*. 2009.
[5]Maybery DJ, Reupert AE, Goodyear M. Evaluation of a model of best practice for families who have a parent with a mental illness. Wagga Wagga: Charles Sturt University. 2006
[6]Dix, K. L., Shearer, J., Slee, P. T., & Butcher, C. KidsMatter for students with a disability: Evaluation report. 2010
[7] Minas, H., Kakuma, R., San Too, L., Vayani, H., Orapeleng, S., Prasad-Ildes, R., ... & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. Mental Health in Multicultural Australia (MHiMA). 2013

Among these cohorts of children who are more likely to struggle, **if support is absent or provided too late, the individual, social and economic consequences are severe**. Children in care are less likely to continue their education beyond the minimum age requirement, and are more likely to attend numerous different schools with lower attendance rates overall.[24] There is also research that young people who have been involved in the child protection system (due to abuse or neglect) are subsequently more likely to be homeless and to engage in criminal activity than those who were not.[25] For children of parents with a mental illness, caring responsibilities can conflict with age appropriate activities and school attendance. There is also evidence of lower levels of attainment in terms of communication, academic competencies and social function in children whose parents have high levels of psychological distress.[26]

The **supports that are available are not consistently reaching the children and families who are struggling**. Data from the Australian Child and Adolescent Survey of Mental Health and Wellbeing Study indicates that only around half of all children who experienced mental illness in the last 12 months had accessed services, and less than a third of parents used services to help support their child who was struggling. There is evidence that the majority of children with mental illness in Australia **do not have enough contact with health professionals to allow for minimum standards of treatment** to be provided.[27] A study involving 846 children aged 4-17 years found that almost half (48.9%) of those with mental illness had not accessed any services in the past 12 months, and even those who had seen a health professional often had minimal sessions – around 7% had just one appointment, and 17% had 2-4 appointments.[27]



[1] Sawyer, M. G., Reece, C. E., Sawyer, A. C., Johnson, S. E., Hiscock, H., & Lawrence, D. (2018). Access to health professionals by children and adolescents with mental disorders: Are we meeting their needs?. *Australian & New Zealand Journal of Psychiatry*, *52*(10), 972-982

In addition to 'dosage' shortfalls, **the quality of service contacts is also not consistently high** – adherence to assessment and management guidelines is also low, with one study finding that rates were 33% for depression and 54% for anxiety, in the context of care for children 15 years and under.[28] So even where children are able to access services, it cannot be guaranteed that they are receiving evidence-based treatments.

Children's mental health appears to be underserved when compared to older age groups. The Australian Child and Adolescent Survey of Mental Health and Wellbeing found that the prevalence of mental illness was similar between those aged 4-11 years and those aged 12-17 years at 13.6% and 14.4%, respectively.[16] However, the survey found that of children with mental illness, those aged 4-11 years were less likely to access a health service provider for emotional or behavioural concerns (46.3%) than young people aged 12-17 years (60.7%). For contact with specialist mental health services, data indicate that many more services are delivered to 12-24 years (> 4 million) than to children under 12 (552,000), with less than 1% of 0-4 year olds and less than 6% of 5-11 year olds receiving a service in 2014-15.[29] Rates of spending on the MBS Better Access program are similarly low, at only 5.6% of the total scheme for children under 12 years of age in 2015-16. Although it appears that service access may also be low for children aged 0-4 years, there are limited data available about the prevalence of social and emotional difficulties experienced in this age group.

Access to services

53% of children with mental illness used **health services** for emotional or behavioural struggles[1]

The following were the most commonly seen health professionals:

- **General practitioner**..... **35.0%**
- **Psychologist** **23.9%**
- **Paediatrician** **21.0%**
- **Counsellors or family therapist** **20.7%**

40% of children with mental illness used or attended **services provided by their school** for emotional or behavioural struggles[1]



Rates of mental illness were higher in those **living outside of greater capital cities** (12.6% for greater capital cities, 16.2% for those outside) but service use was similar (56.7% for those in greater capital cities, 55.1% for those outside)[1]

[1] Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015) The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.

Reasons for insufficient access to services could include[30]:

- lengthy waitlists mean children can't access services when they need them,
- the services or supports children need simply don't exist or are not known to the family,
- the child is refused support from a service because they don't meet severity thresholds or don't have a confirmed diagnosis,
- poor mental health literacy and a lack of awareness of risks amongst parents and teachers,
- stigma around mental health, parenting programs and service access,
- out-of-pocket costs for a service, or
- a lack of specialist workforce to meet the needs of children and families.

For **rural and remote communities, there are even greater barriers to access**. Around 30% of all Australian children aged 0-14 live in rural areas, and 3% live in remote and very remote areas. For many, the nearest services are located in major hospitals a long distance away, and to see a service provider face to face, a round trip of 200km would not be unusual.[31]

The number and type of practitioners able to work therapeutically with children and families is not clearly defined, and in rural and remote areas, is unlikely to include the full range of clinical and allied health practitioners, given known issues of workforce maldistribution. While some **workforce data concerning psychologists and psychiatrists** with child mental health and wellbeing related endorsement are available (see below), ascertaining the full breadth of the workforce and its distribution (mapped according to need) is difficult.

Workforce

5% of **psychologists** in Australia are endorsed in **educational and developmental psychology**[1]

10% Of the psychiatry workforce across Australia and New Zealand are **child and adolescent psychiatrists**[2]

[1] Psychology Board of Australia. Registrant data. Reporting period: 01 January 2020 to 31 March 2020
[2] The Royal Australia and New Zealand College of Psychiatrists. Child and adolescent psychiatry: meeting future workforce needs. Discussion Paper prepared by the Faculty of Child and Adolescent Psychiatry. 2019

Amongst professionals who work with children more broadly, including those in the health, social, disability and community sectors, there is **variability in the level of mental health training, supervision, and continuing professional development** that they have received. In response, the

National Workforce Centre for Child Mental Health was recently established, with the aim of assisting professionals, service systems and organisations that work with children to develop their capacity to identify, assess and support children at risk of mental health difficulties.[32]

1.2 How this Strategy was developed

The NMHC sought input from a **range of perspectives and areas of expertise** to support the development of this Strategy. This was to ensure that the Strategy adequately considers and addresses the range of complexities and challenges related to child mental health and wellbeing. Input was received through an expert advisory group and steering committee (see Appendix A), as well as through consultations (see Figure 1). The consultations included listening to the perspectives of children and young people as this was considered essential for ensuring the relevance and impact of the Strategy.

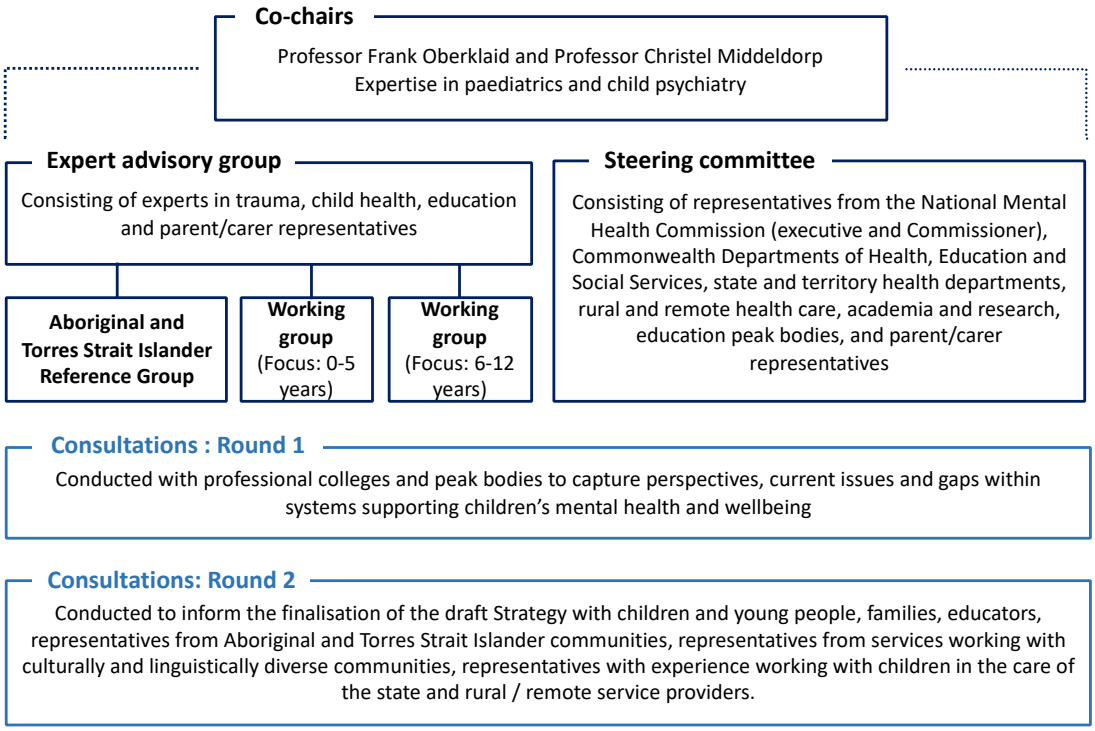


Figure 1: Summary of how the Strategy was developed

Round 2 of our consultations focused on listening to the voices of people and communities who have been subject to the kinds of structural disadvantage that impact negatively on mental health and wellbeing. Where possible, we have included specific actions for these groups in the Strategy, noting that all services should be able to provide culturally appropriate supports. We have also adopted the belief that supports that are appropriate and accepted by Aboriginal and Torres Strait Islander children, families and communities often provide excellent examples of how to meet the needs of all Australian children.[33]

2. An optimal child mental health system

To achieve an optimal child mental health system, this Strategy proposes a number of actions that collectively represent a **fundamental, cultural shift** in the way we think about mental health and wellbeing for children. This shift includes:

- a change in language that refers to a wellbeing continuum that supports early intervention,
- a change in status to give child mental health parity with physical health,
- a change to ensure access and equity in all systems with priority access given to children 0-12 years of age,
- a change towards needs-based access to services, and
- a change in the collective understanding of the roles of families, communities, services and educators.

The changes needed are considerable, but they are achievable. They characterise an optimal system for child mental health and wellbeing. **An optimal system is not aspirational, it is essential**. Anything less means that we have failed to deliver on the rights and needs of Australia's children.

2.1 Principles

The Strategy draws on principles from the United Nations *Convention of the Rights of the Child* and the United Nations *Declaration on the Rights of Indigenous Peoples*. It is **underpinned by a set of eight fundamental principles** (see Figure 2). These principles should be used to guide the way governments, commissioning bodies and service providers operationalise the actions outlined in this Strategy.

These principles recognise that a child's mental health and wellbeing is inseparably linked to their relationships, and familial and situational context. Parental wellbeing is associated with the parent-child relationship and the wellbeing of the child. The optimal mental health system is **child-centred**, supports the child, their family and, when necessary, their community. We also recognise the impact that community membership can have on perceptions and experiences of mental health and wellbeing.

The optimal mental health system does not wait until a child is experiencing a mental illness before providing supports, but is **prevention focussed,** promoting the wellbeing of all children from birth and **enables access to early intervention** whenever necessary. For this to occur, parents, carers, and professionals need to have an understanding about what is typical for children at various developmental stages, and what are the signs that the child might be struggling. In the optimal system, families are armed with this knowledge and with strategies for supporting their child's social and emotional development from birth, as is the case with physical development. To help families to support children, the Strategy focuses on opportunities to monitor and promote children's mental health and wellbeing, as well as empowering help seeking when additional support is required.

In the optimal mental health system, all doors lead to help and **services are designed and delivered based on the needs of children and families**. This means that services are culturally responsive and are developed, delivered and evaluated using the principles of genuine co-design. It also means that a child does not require a diagnosis before help is available; service access would be based more on how they are functioning socially and educationally rather than on whether they meet diagnostic

criteria. There is also **coordination and collaboration between the services** that support children and families, minimising stress and burden on children and families during times of difficulty and adversity.

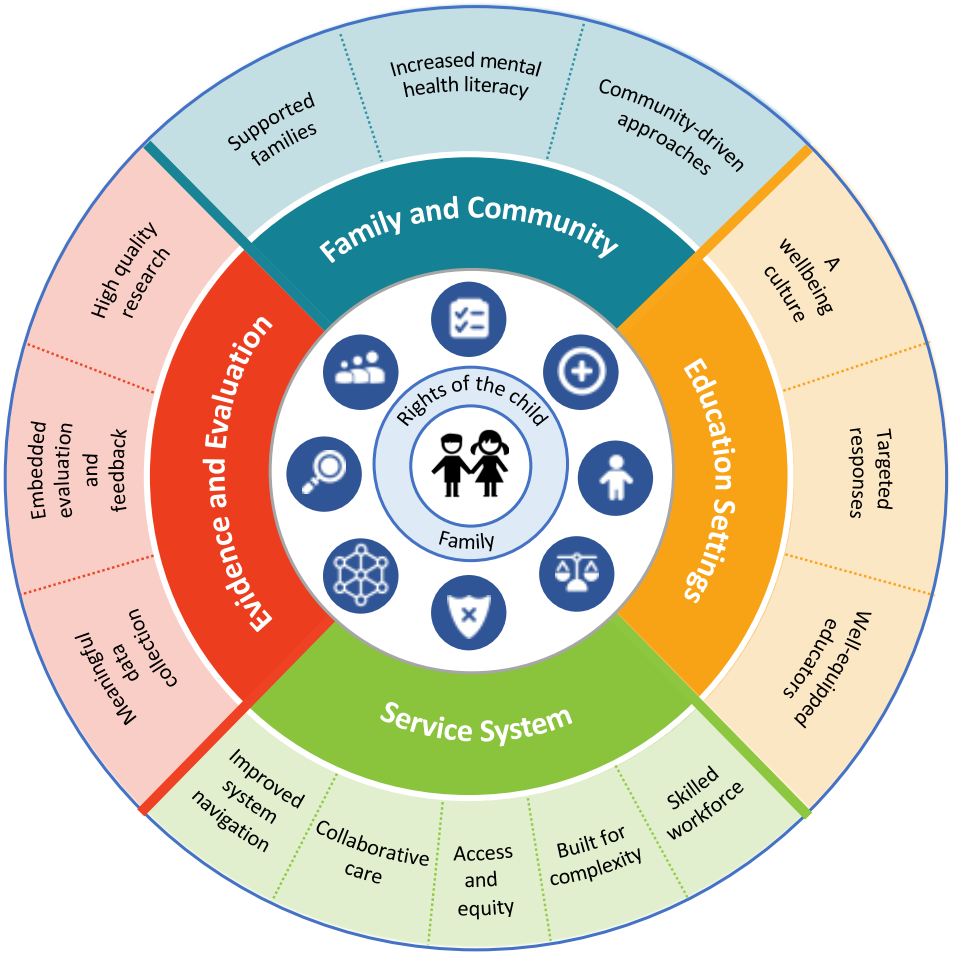
The Strategy presents the rationale for **relevant services working together in supporting children and families**, both within sectors and across sectors including health, education, justice, disability and social services (see Objective 2.2). From the child and family perspective, all services that they interact with would communicate and work together, to ensure a streamlined and comprehensive experience of care. This includes seamless referral processes when moving between services – for example, in the transition from childhood to adolescent services.

In the optimal mental health system, programs and services work with children and families to provide a consistent and high quality of support, including clinical intervention where relevant. Programs and services need to be accessible (and continue to be over time) to all children and families, and be **developmentally appropriate and culturally responsive**. This means that families can access local services regardless of their resources, geographic location (e.g. rural or remote) or cultural background. The optimal system is also comprised of **evidence-based programs and services**, where the impact on outcomes is monitored and evaluated, and funding is allocated accordingly.

The Strategy emphasises the importance of effective services and programs for all children and families. We cannot **promote help-seeking without ensuring that the help available is effective**. To ensure children's experiences of services are positive, the Strategy recommends a system where mental health and wellbeing services are co-designed (or at least informed) by the children and families who are likely to use them, with **ongoing evaluation, and opportunities for feedback and quality improvement**. Ensuring services are based on the needs of their communities might require changes to existing services or perhaps even new service types. Our intention is that the standard of support and care provided to all children and families is consistent, no matter their circumstances.

The scope of supports needed for children and families extends beyond just the health sector. Increasing attention on social determinants[6] is expected to reduce the number of children and families vulnerable to poor mental health. In this context, while the Strategy is **strengths-based and** focused **firmly on supporting and engaging with families**, it cannot be assumed that the family home is a safe environment for every child. The Strategy addresses situations where remaining in a particular family environment has not been deemed to be in the best interest of a child. In such cases, the Strategy emphasises the duty of care owed by the State to children for whom they are proxy parents (see Objective 2.4).

[6] The **social determinants** of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between individuals, families and communities. The 'social determinants' of mental health apply especially for children, who are reliant on the adult world to provide the necessities of life and to support their mental health and wellbeing.



Strategy Principles

Child-centred
Respecting and promoting the role of communities, parents, families and carers

Strengths-based
All services have a perspective that builds on child and family strengths, to inform a holistic and family-centred approach

Equity and access
Ensuring that all children and families have access to health, education and social services

Prevention-focused
Both universal and targeted prevention of mental illness by promoting mental wellbeing

Universal system
Programs and services are developmentally appropriate, culturally responsive and treat children in the context of families and communities.

Evidence-informed best practice and continuous quality evaluation
The use of data and indicators to create a continuous feedback loop between research and clinical practice.

Early intervention
Early intervention for those in need, while addressing the impacts of trauma and social determinants

Needs based, not diagnosis driven
Service delivery based on individual needs and reduced focus on requiring a diagnosis to access services

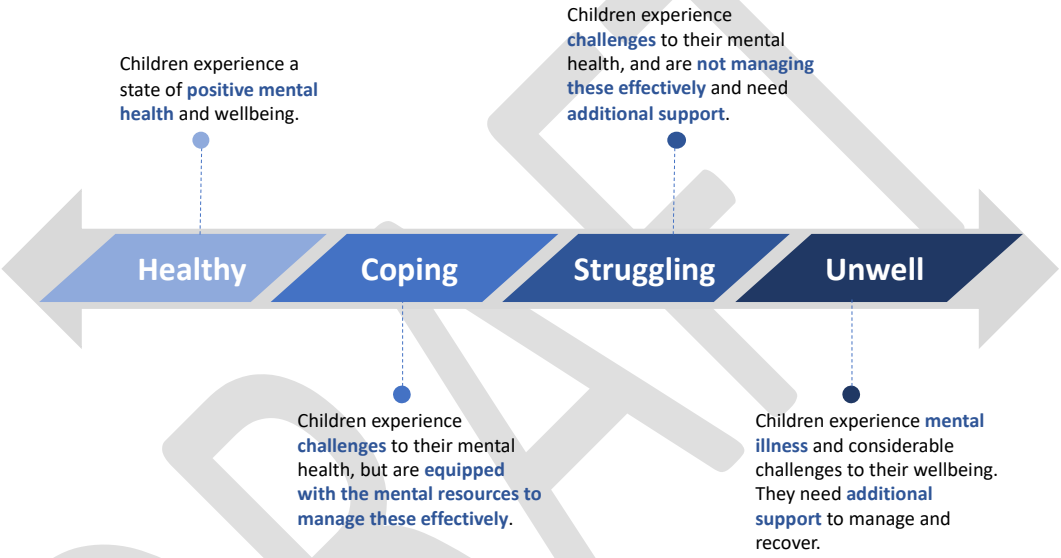
Figure 2: National Children's Mental Health and Wellbeing Strategy, with description of the foundational principles.

2.2 Wellbeing continuum

To support the cultural shift this Strategy aims to achieve, we have **adopted a continuum-based model of mental health and wellbeing**, with non-stigmatised language characterising the various experiences of wellbeing (see **Box 1** below).

Box 1: A mental health and wellbeing continuum

Children's emotional experiences cannot always be distinctly defined as healthy or unhealthy, as there are varying levels of mental health and wellbeing. Therefore, it is more accurate to describe emotional experiences as falling along a continuum. The figure below outlines the continuum model of mental health used to guide this Strategy.



The continuum approach highlights that there are opportunities to promote improved wellbeing and possibly intervene before a child becomes unwell. It also acknowledges that a child may have a diagnosed mental illness, but function well socially and educationally (i.e. 'coping'). Similarly, a child who is 'struggling' would not require a diagnosis, but would be experiencing a decline in their usual functioning or anticipated developmental trajectory.

The optimal mental health system includes universal services and programs that help children remain in, or move to, the healthy end of the continuum. In addition, it would provide targeted supports and services for children who are struggling.[34] This Strategy proposes that children should be able to access funded services at the point that they are beginning to struggle, rather than only once they are unwell and have received a diagnosis.

This description of mental health and wellbeing also introduces terminology that is more approachable than the traditional language of 'mental health' and 'mental illness', which can be stigmatised and not well understood. As such, structuring a system around this continuum offers a common language to help families, health professionals and educators to discuss children's emotional wellbeing.
Consultations also found that this continuum approach aligns well with Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing[vii], which focus less on mental illness and more on holistic approaches to supporting wellbeing.

[vii] **Social and emotional wellbeing** is generally the preferred term for both physical and mental health for Aboriginal and Torres Strait Islander peoples and communities. This holistic concept includes but extends beyond conventional western concepts of mental health and mental illness. It recognises the importance of cultural determinants of health such as relationships with family, kin and community, and connections to land and sea, culture, spirituality and ancestry, as well as social determinants such as employment, housing and education.

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The introduction of the continuum concept appears to have widespread support. Though the question of the most appropriate words to use at the four anchor points is still the subject of debate, as is the question of whether to introduce a fifth anchor point – 'thriving'. It is suggested that **thriving** reflects not only the absence of psychological or behavioural problems, but also the presence of strengths and wellness.[35] Thriving can be viewed as a core set of life skills essential to emotional regulation, social participation and global citizenship. The EPOCH model (outlined below)[36] suggests that thriving has 5 dimensions:

- ***E**ngagement* - the capacity to become absorbed in and focused on what one is doing, as well as involvement and interest in life activities and tasks. Very high levels of engagement have been referred to as "flow".[37]
- ***P**erseverance* - the ability to pursue one's goals to completion, even in the face of obstacles.
- ***O**ptimism* **-** is characterised by hopefulness and confidence about the future, a tendency to take a favourable view of things, and an explanatory style marked by evaluating negative events as temporary, external, and specific to the situation.
- ***C**onnectedness* - the sense that one has satisfying relationships with others, believing that one is cared for, loved, esteemed, and providing friendship or support to others.
- ***H**appiness* - is conceptualised as a relatively steady state of positive mood and feeling content with one's life, rather than a momentary emotion.

We recognise that language is important in this context, and that the words used for the anchor points along the continuum need to be carefully considered. Further work to address this is warranted, and we would encourage this to be done in an empirical manner by systematically eliciting the views of stakeholders, families and professionals. Notwithstanding this, we want to advocate for language that recognises that mental health is experienced on a continuum, and so we will use this terminology throughout the Strategy.

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3. Focus Areas

To help Australia achieve the cultural shift towards an optimal child mental health and wellbeing system, the following sections outline **key objectives and actions under four focus areas**.

- Focus Area 1: Family and community
- Focus Area 2: Service systems
- Focus Area 3: Education settings
- Focus Area 4: Evidence and Evaluation

Each Focus Area consists of a number of **objectives that need to be achieved** for a strong system for child mental health and wellbeing. For each objective, we have included a section focussed on **examples of where things are currently working well** – 'what we can build on'. These are not intended to be an exhaustive overview of all the positive work in a particular area, but rather to provide insights into what is already being done and how the Strategy might build on them.

It's also important to note that the order in which the Focus Areas and associated actions are presented in this Strategy is not indicative of their priority for attention or implementation. In fact, many of the proposed actions would need to be **implemented concurrently as they are dependent on each other**. These following sections should be read with this in mind.

Objectives collectively span all aspects of a child's experiences of mental health, from promoting wellbeing and identifying children who are struggling through to providing evidence-based care and feedback and evaluation (see Figure 3).

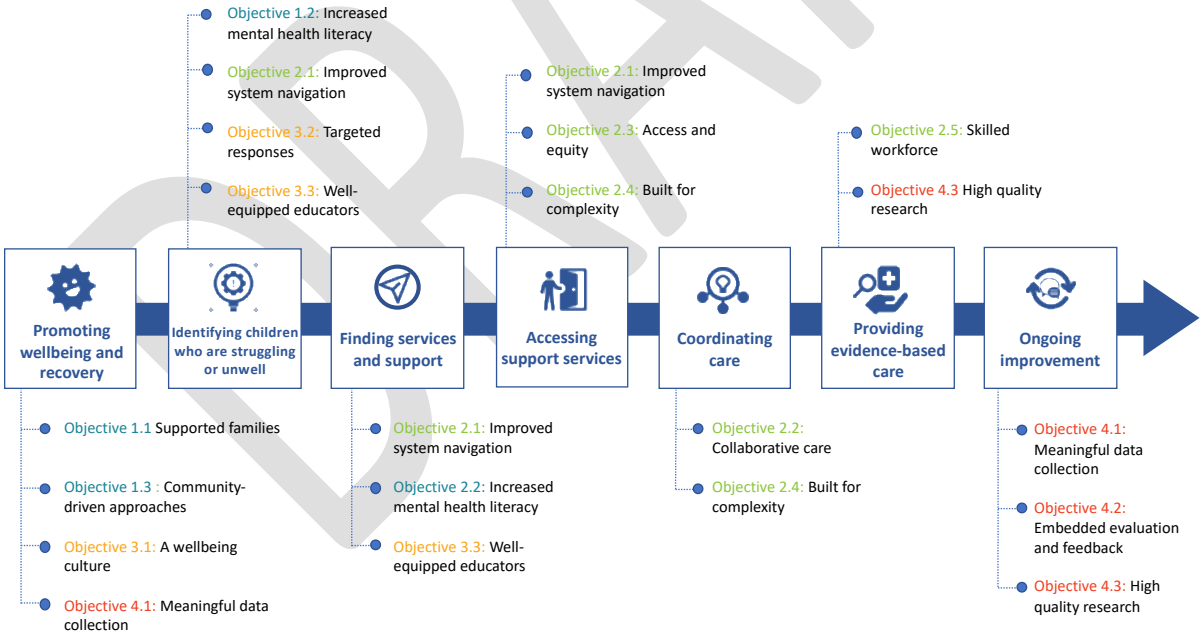
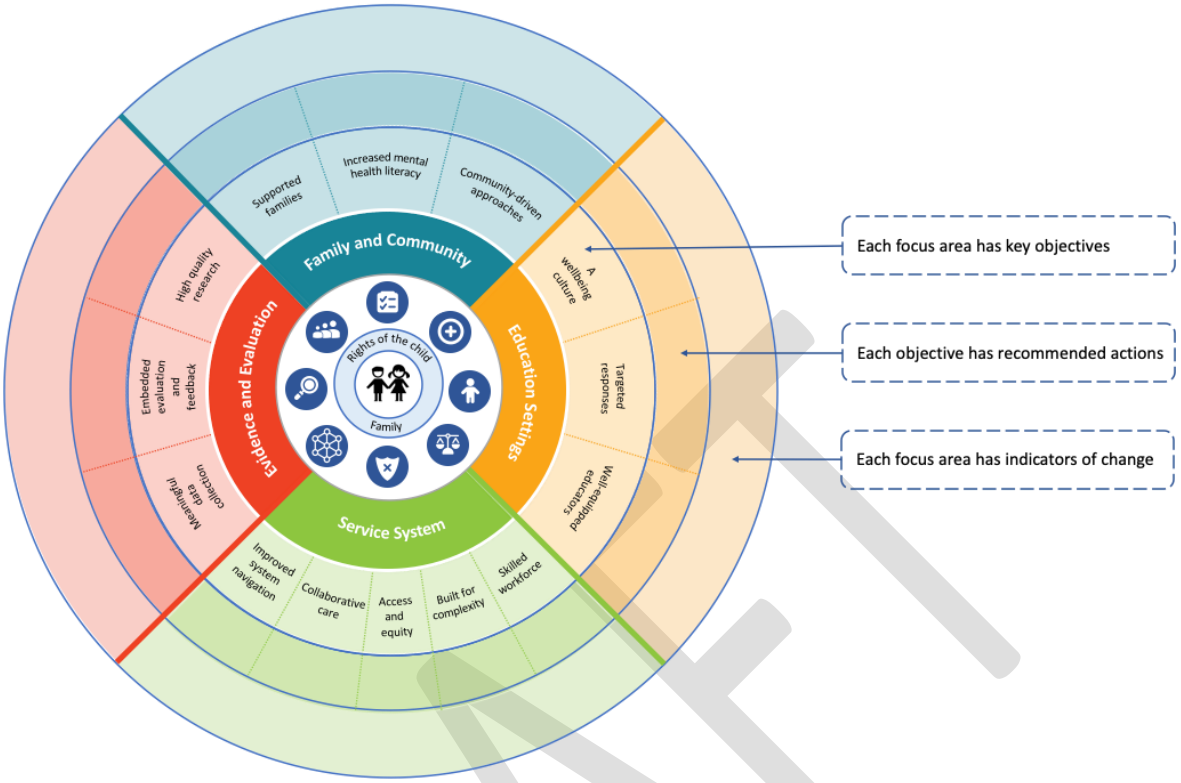


Figure 3. Objectives of the National Children's Mental Health and Wellbeing Strategy

For each recommended action, we have suggested which level of government or sector is *primarily* responsible in the Summary of Actions section. This is not intended to feed into the territorial silos that are problematic, as many of the actions will require significant involvement across sectors, jurisdictions and governmental portfolios.

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Each focus area has a number of proposed **indicators of change**. The purpose of these is explained further in chapter 4 on implementation.



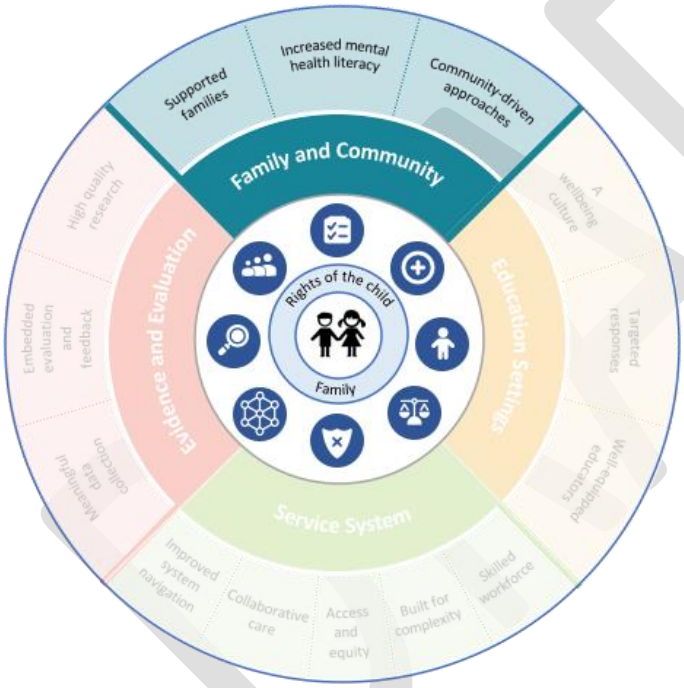
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Focus Area 1: Family and community

The family environment is the single most important influence on a child's development, with family relationships and interactions critical to positive mental health and wellbeing.[38] The first years of a child's life provide a foundation for their future, with quality parenting, high levels of family functioning and access to social and family supports contributing strongly to optimal development.

The Strategy identifies the importance of empowering families to promote mental health and wellbeing as part of routine parenting and actively collaborate with services when these are required. The Strategy is also sensitive to the cultural, geographic or experience-based communities with which children and families identify and recognises the impact that community membership can have on perceptions and experiences of mental health and wellbeing.

"Deliberate family attention is something that the system sorely lacks and is never provided when you need it… having something that's family centric… and able to hear and stand by and with families [is needed]"—Parent / carer of a child with mental illness



Family and community objectives:

1.1. Supported families

1.2. Increased mental health literacy

1.3. Community-driven approaches

Objective 1.1 Supported families

Support for families starts with looking at **risk factors and challenges in the perinatal period**. While this Strategy predominantly focusses on birth onwards, there are important issues (such as foetal alcohol syndrome) that arise in childhood and have their origins in the antenatal period. For families, the perinatal period (conception to 12 months post birth) is also a high-risk time for depression and anxiety, impacting one in five mothers and one in ten fathers or partners. In addition to impacting on the family and child's wellbeing, perinatal depression and anxiety poses a high economic cost of approximately $877 million in Australia in 2019.[39] Identifying parents who are struggling (or likely to struggle) and connecting them with supports is an effective strategy in promoting the wellbeing of their child (action 1.1.a).

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All parents and carers want the best for their children. But **not all parents and carers know what they can do to help their children develop positive mental health** nor what signs to look for when things might not be going well for their children. While there is a range of resources already available to provide guidance on what parents and carers can do, many families would not be aware of them (actions 1.1.b and 1.1.c).

"Trying to access services for me as a kid was terrible because I am a single child with a single parent as well, and there wasn't much support for my Mum to be able to help me access things" – Young person with experience of mental illness

Caring for young children is challenging, but it is important that parents understand effective parenting strategies. **All parents and carers can often benefit from learning evidenced-based parenting tools and strategies**. Parenting programs have been found to have positive outcomes for child mental health and wellbeing.[40,41] They have also been proven to have good outcomes for families of children both with and without developmental difficulties, and when delivered face-to-face, online, in groups, or as self- directed learning.[42] They have also been successfully tested in rural and remote communities, with positive outcomes.[43] For these reasons, **parenting programs should be routinely offered** at key transition points and developmental milestones in a child's life. (action 1.1.c)

Despite evidence of positive outcomes from parenting programs, **parents can be reluctant to engage** with them. There are strong perceptions that parenting is something that should be natural and instinctive.[44] This means that parents and carers can feel like they are failing if parenting does not feel easy or natural for them. As a result, parents and carers may not want others to know that they are struggling and feel defensive about participating in parenting programs. There is also stigma due to the association of parenting programs with child welfare contexts, rather than those pitched as providing practical information on children's development (action 1.1.d).

By promoting such programs to *all* parents, stigma of 'bad parenting' as a driver for program engagement is minimised. In addition, the way parenting programs are discussed by service providers is important – for example, framing parenting training around the notion of supporting child development results in better engagement than focusing on learning how to be more effective as a parent.[44] Higher (or ideally universal) levels of participation in parenting programs would mean that those who require assistance would benefit, and those who were not struggling would be better equipped to prevent their own future struggles or support other parents who struggle (action 1.1.c, action 1.1.d).

Other universal supports include parent helplines, available nationally and across each state and territory (action 1.1.e). Many parents also enrol in antenatal courses associated with their midwife or obstetrics practice, usually held at the same location as the birth clinic. There may also be similar courses offered via community health centres (action 1.1.f).

Box 2. Children and families that are 'hard to engage'.

Just because a service system exists does not mean that all families will engage with it. Julian Hart published a seminal paper in 1971 titled 'The Inverse Care Law', which proposes that the availability of good medical care tends to vary inversely with the need for it in the population served. In other words, those children and families who would benefit the most from services are the least likely to utilise them.

There are a number of factors that may act as barriers to receiving timely and appropriate care. In addition to the issues regarding accessibility (see objective 2.3), there may be (1) structural barriers – families not aware that the service exists, the hours of opening may be inconvenient, out of pocket expenses may make the service unaffordable, long waiting lists, or lack of transport to get to service; and/or (2) relationship or

interpersonal barriers – cultural sensitivities, language barriers, professionals may be perceived as having lack of empathy or poor listening skills, or parents may not have trust or be afraid the child will be removed from the family.

To address these barriers and ensure that all children and families engage with the service system as required, there needs to be systematic and organised outreach to these vulnerable families, with particular effort placed on building relationships with parents. This outreach depends on context and may take different forms, and will always be challenging, time consuming and require specific additional resources for a community-based service system. Non-threatening and non-stigmatising existing universal programs, such as immunisations, may be a useful base from which to plan outreach programs.

In some cases, children will have no contact with early childhood learning services, and their first experience of formal education will be at school. The ABS reports that around 17% of 4-year olds are not enrolled in a pre-school program.[45] While removing barriers to early childhood education is important due to the social and economic benefits, alternative touchpoints exist for reaching children prior to school such as visits to a General Practice (objectives 2.3 and 2.4), and improving outreach to vulnerable families (objective 1.1). Health and social services connected with adults (e.g. Centrelink) provide data linkage for child supplement or associated payments. These could enable the identification of children who are disengaged from formal supports and services including health and education. This responsibility belongs to all agencies, departments and services providers across local, state and national levels (action 1.1.g).

Where children are not attending an early childhood education service, it is critical to engage them via universal health care systems and social services. Options to achieve this include outreach and family support. Other more informal options include home-visiting, mobile pre-schools, or supported playgroups that are facilitated by trained early childhood professionals.[46]

Things we can build on

In Queensland, **access to the evidence-based parenting program, Triple P, has been funded for all parents** of children up to age 16.[47] Parents and carers can access it on a voluntary basis at no cost, and uptake has increased for many vulnerable groups during the current pandemic.[48] The program is based around the development of self-regulation, and is underpinned by five positive parenting principles; safe and engaging environment, positive learning environment, assertive discipline, realistic expectations, and parental self-care.[49] The original trial of the online format found that it increased parental confidence in managing problem behaviours, lowered the use of ineffective discipline, and parent users reported less child conduct problems.[50]

Foster parents and adopting parents undergo mandatory parenting skills training, and parenting support programs are provided by maternal and child health centres antenatally and postnatally. They are also available via early childhood learning services, schools in the public and private sector, and in child mental health services in some jurisdictions e.g. NSW. Although the extent to which these programs incorporate content focused on child mental health is variable (action 1.1.h).

As noted in the Productivity Commission's Final report,[51] there are improved outcomes with the **use of regional coordinators in adult clinical mental health services** to facilitate family-inclusive practice. Victoria's Families where a Parent has a Mental Illness (FaPMI) initiative introduced coordinators in each catchment area, as a way to build capacity of the local workforce to improve identification and support for parents and children. Results from a preliminary, targeted evaluation compared two mental health services (one rural, one urban) with and without a FaPMI coordinator. The evaluation found that adult mental health clinicians had greater knowledge and skills regarding the effects of parental mental illness on children and were more able to provide referrals to family support service after the FaPMI services were introduced.[52]

The Commonwealth Department of Social Services funds early intervention and prevention services and resources focused on children aged 0-12 years with the aim of improving development and wellbeing and supporting parents and carers. The **Intensive Family Support Services** focuses on reducing child neglect and providing vulnerable families with practical parenting education and support for 12 months. Other programs including the **Child and Parenting Support Service** and the **Home Interaction Program for Parents and Youngsters** include services such as supported playgroups and school readiness programs to help parents develop their child's pre-literacy and pre-numeracy skills.[53]

Actions 1.1	
a.	Implement perinatal mental health screening for expectant parents in maternity services (public and private), monitoring and reporting on alignment with the National Perinatal Mental Health Guidelines (see action 4.1.a).
b.	Ensure evidence-based resources that provide practical suggestions on how families can support children's emotional wellbeing are made easily accessible and promoted widely. These must include specific resources for families where there are additional physical, neurodevelopmental or cultural needs, developed via genuine co-design.
c.	Routinely offer evidence-based parenting programs to parents and carers at key developmental milestones for their child – for example, the perinatal period (from 6 weeks), at commencement of early childhood education (age 2-4); transition to primary school (age 4-6), when their child moves to the penultimate year of primary school (age 10-11); and at the commencement of high school (age 12+).
d.	Implement a nation-wide campaign aimed at promoting the availability and value of parenting programs, with specific efforts to address stigmatising attitudes towards participation in such programs.
e.	Promote parent helplines and hotlines (available in each state and territory) as the first 'port of call' for any parenting concerns.
f.	Include emotional wellbeing modules and information about locally available supports in all antenatal and parenting training courses delivered to new parents.
g.	Design systematic methods for identifying children who do not start primary school by the required age, with this prompting a compassionate outreach of support to engage the child and family.

Objective 1.2 Increased mental health literacy

Despite increased general awareness of the importance of mental health in Australia over the past decade, the majority of parents and carers in one study (65%) would still **not be confident that they could recognise signs of poor mental health in their child**.[54] Parents and carers report that it is particularly challenging to identify when a child is struggling with their mental health when there are also a range of other situational factors impacting on the family. Difficulties identifying when children are struggling can delay access to interventions and support.

"When you're right in it, it's so difficult to see… it's like catching smoke… things unravelled well beyond where they should have really. It still shocks me… I just wasn't equipped"—Parent / carer of a young person with mental illness

Signs that children are struggling can look quite different to adults or young people. These signs also change over time as children go through various developmental stages that affect language acquisition, impulse control and behavioural regulation, and the development of emotional intelligence.[55] Consequently, children's social and emotional needs and capabilities may vary greatly depending on their age. Where signs of not-coping (e.g. changes in behaviour) are missed, so too are opportunities for prevention and early intervention, and access to supports in a timely manner. Children also have less autonomy than young people or adults and are therefore dependant on the adults around them (parents, carers, educators, health professionals) to identify that help is needed and to facilitate access to it (action 1.2.a, 1.2.b). Some parents may identify that their child is struggling, but be **uncertain about whether the issues are "severe enough" to warrant additional intervention** beyond the support the parent or carer can provide. A lack of clarity about when parents should seek professional support for their child only adds to the delay (action 1.2.a).

Further complicating these matters, different families and communities may describe a child's mental health very differently. A family's understanding and prioritisation of mental health can vary greatly due to various factors, such as **cultural and language background**. In some cultures, even conceptualising emotional or behavioural struggles under the umbrella of 'health' may be unfamiliar. For others, the term 'mental health' may be associated only with very severe mental illness and not resonate with the struggles that they might observe in their child (action 1.2.b).

Increasing mental health literacy and reducing stigma must be supported by the whole community. Children and families interact with many different services and organisations that can either reinforce misperceptions and stigma or help to create positive change. The service system (Focus area 2) and education system (Focus area 3) are discussed in detail in this Strategy, however children and families participate in many other areas of the community. This may include sporting clubs, after school programs, performing arts groups, faith-based groups and a range of other community organisations. Many leaders working or volunteering in these areas of the community would see children who are struggling, but not always know what to do or how they can help. There is an opportunity through community organisations to create a positive culture in relation to mental health and ensure reliable and accurate information gets to families (action 1.2.c).

Things we can build on

The Commonwealth's **Head to Health website** contains information for adults on supporting children with their mental health and wellbeing, including links to additional resources and public forums.[56] There is also work underway to design, develop and deliver regular child development and mental health literacy messaging to parents via a digital platform. The program will be delivered through the Raising Children's Network in collaboration with the Murdoch Children's Research Institute. Given that parents frequently search online or communicate with other parents via social media, this new online platform could provide an effective vehicle to reach parents who are worried about their child's emotional or social development.

Actions 1.2

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a.	Plan and implement a program of activities (e.g. campaigns) to increase parents' and carers' understanding of the signs that a child needs mental health support. These activities should directly address any common myths or misconceptions about child mental health and wellbeing.
b.	Ensure mental health literacy resources do not assume any background knowledge about mental health, use terminology and examples that have universal relevance wherever possible, and are translated into languages other the English.
c.	Provide resources about mental health to those in community organisations working or volunteering with children, including information about where they can direct children and families if they need additional mental health and wellbeing support.

Objective 1.3 Community-driven approaches

Like adults, **children are members of communities**. As they grow, they will develop a sense of belonging with their family, their neighbourhood, their school, their sporting team, their church, and in other aspects of their lives. Communities may be based on culture, geography, or simply shared experiences such as schooling, sport etc. One of the central principles of this Strategy is to consider each child and the context in which they live. This means including their family and their various communities in our efforts to understand and address the child's struggles. In some instances, it may be necessary to support the health of the child's community in order to improve the child's wellbeing (action 1.3.a and 1.3.b).

"Think of [mental health and wellbeing] beyond the individual child or young person… that broader connection to how the family's travelling but also community in general"—Professional working in migrant and refugee services

The **impact of social and geographical environments on child mental health and wellbeing** is well known. With evidence that children's temperament develops over time in response to environmental factors, including neighbourhood disadvantage (marked by access to nature and public open space and inadequate infrastructure) which can diminish their experience of community.[57,58,59] In contrast, while family finances and public services go a long way to shaping children's development, strong and supportive relationships, both inside and outside the home can have a protective effect, especially for children of minorities and those of low socioeconomic status.[59,60]

"Identify formation where the social norms are fairly strong and of feeling a little bit different from other students in the community [is challenging] – not finding like-minded people and struggling with identity can be a big driver for health issues for young people"—Professional working with rural / remote communities

Things we can build on

Collective impact and place-based initiatives are increasingly being proposed to address complex social issues in a manner that is sensitive and adaptive to individual communities. **The Communities that Care program** is an example of an evidenced-based community-change process that involves the development of targeted frameworks to address issues facing children and young people tailored to local needs.[61] Through the program, key stakeholders in the community are identified and recruited, and data is collected about young people in the community to assist with identifying areas for action. A unique plan that addresses the community's needs is then developed,

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implemented and evaluated. A range of different programs may be included as part of each action plan, such as mental health first aid training, social marketing campaigns, and parenting and child wellbeing programs. This program has demonstrated success in supporting prevention and early intervention for health and social problems amongst children and young people in Australia and overseas.[62,63]

Children's Ground is an Aboriginal and Torres Strait Islander-led and designed place-based approach for working in Australia's most disadvantaged communities. The first partnership established by Children's Ground is with the Mirarr people in the Northern Territory, through their organisation the Gundjeihmi Aboriginal Corporation.[64] The Children's Ground approach involves working with families with children pre-birth through to 8 years old targeting the social and cultural determinants of education, health, and wellbeing. It addresses five platform areas, each of which intersects with wellbeing; learning, family health, economic development, community development and creative and cultural development.[65] Evaluation of Children's Ground found that the approach increased children's engagement in learning and levels of adult employment, as well as greater inclusion of the community in governance, design, delivery and evaluation of services.[66]

Characteristics of a successful place-based approach include[67]:

- Communities participate, lead and own the intervention;
- There is investment in capacity building;
- There is adequate time for transformation to occur;
- There is adequate funding for pilots, demonstration projects and infrastructure, and to support initiatives and ideas that flow from the project;
- Effective relationships between stakeholder groups;
- There are processes to rigorously measure and evaluate outcomes;
- There is a 'good fit' – i.e. the scale of the project is appropriate to the policy challenge.

Actions 1.3	
a.	Identify and invest in communities that could benefit most from community level support; for example, those with low school attainment, high unemployment, poor physical and mental health, high imprisonment rates, high incidence of child abuse or neglect, or any other factors that contribute to or maintain an environment of social and economic disadvantage.
b.	Work with communities to develop and deliver tailored programs focused on improving child wellbeing and based on the key characteristics of successful place-based approaches. These may build upon existing social networks organically built through contact with maternal and child health, educational settings, sport and other community settings.

The below table outlines some proposed **indicators of change**. If the objectives of this focus area are realised, we would expect to see improvements in the below.

Focus Area 1: Families and Communities – indicators of change	
1.1	The extent to which parents are aware of, and routinely access, evidence-based parenting resources, parenting helplines and parenting programs.

1.2	Use of systematic methods to provide compassionate support for children and families who are hard to engage via usual pathways, e.g. formal schooling.
1.3	Level of understanding in families and the community about child mental health and wellbeing, and about best options for obtaining additional support if needed.
1.4	Implementation progress of place-based approaches to reduce risk factors amongst communities that have been identified as having complex needs.

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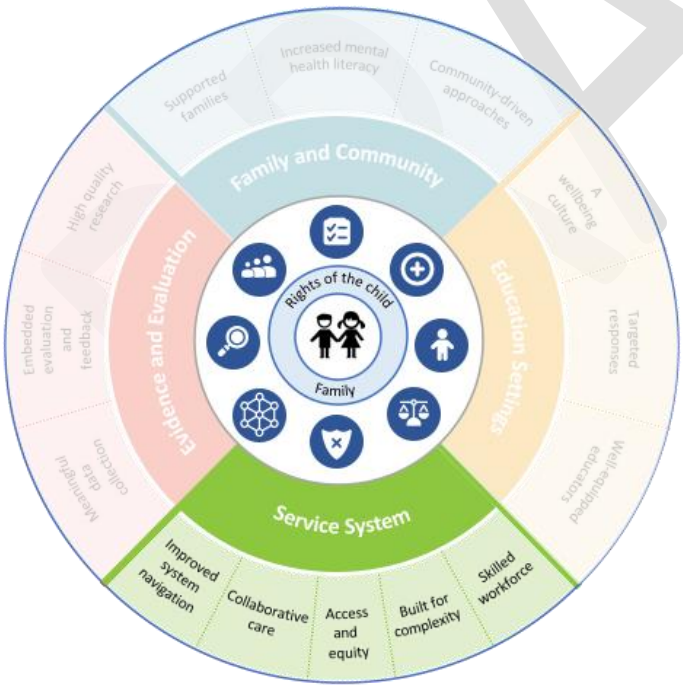
Focus Area 2: the Service System

The current service system (both health and social services) is in great need of reform. **Access to mental health services does not currently match the needs of children aged 0-12 years**. There are:

- unclear and inadequate entry point for services,
- unhelpful requirements for a clinical diagnosis before treatment is provided,
- lack of services available after hours or at affordable rates, and
- structural barriers that feed a disconnect between primary services (e.g. GPs) and mental health services.

If families recognise the need for professional help**, the system is hard to navigate for both families and professionals**. The service system is not oriented to intervene as early as possible and does not target factors that increase a child's vulnerability. There can be long waits or high thresholds of severity, resulting in services focusing on acute and critical responses well after the emergence of a child's struggles. Some services only focus on particular diagnoses despite the knowledge that comorbidity is very common and intervening before a child warrants a diagnosis may be more effective.

While mental illness is common across Australia, **Australians living in rural and remote areas access services at a much lower rate**. In 2016-17 people living in remote areas accessed MBS funded mental health services at a rate of 81 service encounters per 1000 people, compared with 495 encounters per 1000 people in major cities.[68] This may be due to a number of factors, including limited access to services and inequitable workforce distribution.



Service system objectives:
2.1. Improved system navigation
2.2. Collaborative care
2.3. Access and equity
2.4. Built for complexity
2.5. Skilled workforce

Objective 2.1 Improved system navigation

Responsibility for finding the right supports often falls to parents to act as system navigators for their child. Families often **feel daunted and lost as they try to find and access the services** they or their child need. There is often a sense of 'luck' when families connect with the right services for

them, or they happen to have been in the 'right conversation at the right time'. This means that many families are likely to be unfairly missing out to their detriment. The element of luck needs to be removed from the system so that families consistently get the services they need when they need them.

"The thing I found most difficult was learning where the resources were and how to access them. I stumbled across the help we found for our daughter"—Parent / carer of child with mental illness

One study suggested that less than half (44%) of parents are confident in knowing where to go for professional help if their child is experiencing mental illness.[54] **There is a lack of clear information about where they can access support** for their children. As a result, families seek information about available supports through various channels, including via other parents, schools, or health professionals (e.g. GPs or paediatricians). A lack of clear, consistent information about where to seek help delays access to services and creates additional stress and burden for families (action 2.1.a).

The current system is fragmented. There is lack of coordination between various sectors, jurisdictions and organisations involved in supporting children's mental health and wellbeing. Even when professionals (e.g. early childhood educators, maternal child and family health nurses, GPs) identify that a child is struggling, there are not clear pathways for referring families to appropriate care. As an example of the complexity of the service landscape, recent service mapping in Victoria identified 147 Commonwealth and State Government programs and service types.[69] It is incredibly difficult for service providers to navigate this many options, let alone for a family in distress. There are also poor connections when families move across regions or interstate and want to connect with equivalent services in the new location (action 2.1.b).

In addition to the difficulties navigating the sheer number of options, the **services are not organised in a way that provides a logical pathway for care**. For example, there can be a disconnect between assessment services and treatment services, such that many publicly funded multi-disciplinary programs provide assessments only. The typical trajectory for a child who is struggling often involves a series of sequential assessments punctuated by long waiting times before a care plan and/or diagnosis can be formulated (action 2.1.c). **Box 3** describes a model for addressing this and other systemic issues for children and families seeking support and care.

Similarly, **age thresholds for different services don't allow smooth transitions in care** from childhood into adolescence, and later into adulthood. For example, infant mental health (0-4 years) can be a source of relatively consistent care via a single service, however children are then ineligible to continue with the service when they reach school age.[15] For young people who have been receiving care via Child and Adolescent Mental Health Services (CAMHS), the shift to adult mental health services can be jarring.[70] The timing of transition is often seen by young people as arbitrary and misaligned with their needs and developmental stage (action 2.1.b).

Things we can build on

HealthPathways is an online health information portal for GPs to be used at the point of care. It is an example of an approach that has been used to assist clinicians to make assessments and referrals in a range of areas of health including suicide prevention and routine antenatal care.[71] Rather than traditional clinical guidelines, 'pathways' in the online portal are developed through locally-based expert consensus to reflect agreements between primary and specialist services about how individuals with particular conditions will be managed in the local context. As well as supporting a

consistent and best-practice referral approach, HealthPathways also offers cost savings through reductions in unnecessary referrals.[72] At this point, not all regions are using HealthPathways and/or may not have pathways established for children's mental health. Also, HealthPathways is typically only accessible by GPs (and some hospitals), but not other service providers or families in the community.

Aboriginal and Community Controlled Health Organisations (ACCHOs) are primary health care services initiated and operated by local Aboriginal communities. Their model involves holistic interdisciplinary care and is distinct from traditional health services as it responds to health at the individual, family and community health level. A typical ACCHO may offer an array of clinical services delivered by GPs, practice nurses, midwives, child health nurses, dentists, psychiatrists, drug and alcohol workers, psychologists, psychiatrists, pharmacists, dietitians and podiatrists. This is often coupled with a social support team to provide social and emotional wellbeing programs and targeted interventions such as smoking cessation or parenting groups.[73]

Strengths of the ACCHO model include:

- Taking a holistic approach to people's care – including considering multiple areas of a child's life and factors that may influence their mental health and wellbeing;
- Having a 'no wrong door' approach, so when someone reaches out for support, they are never turned away without at least being linked in with the services they need; and
- Providing warm referrals to services to reduce the burden on community members to navigate the complex service system on their own. This entails the service provider making contact with the provider or organisation on behalf of the child or family who are being referred, rather than just providing information.

Box 3: Model of integrated child and family care

A model of integrated child and family care could address multiple objectives across this Strategy including improved system navigation (objective 2.1), collaborative care (objective 2.2), access and equity (objective 2.3), a system built for complexity (objective 2.4), and a skilled workforce (objective 2.5). This model also has potential to contribute to providing supports directly to families (objective 1.1), supporting place-based approaches (objective 1.3), collecting meaningful data (objective 4.1), and providing a best-practice example for embedding evaluation and research (objectives 4.2 and 4.3).

The model brings together a multidisciplinary team consisting of child and youth psychiatrists, paediatricians, psychologists, mental health nurses, occupational therapists, speech pathologists, physiotherapists and social workers. All of these disciplines can play a role in the assessment and treatment of a child mental illness.

Having the model deployed at multiple locations around the country would create a network of skilled service providers. By offering services via a combination of face-to-face, phone and video, the model would have the capability to support a large swathe of communities.

Children and families could be referred by a GP or another primary care clinician for assessment and, if necessary, treatment. Consistent with the recommendations in this Strategy, staff would also be able to identify parents and carers who are struggling with their own mental health and would connect them with the necessary supports (action 1.2.d).

We propose that this model could provide (1) support for children who have complex needs, (2) psychological treatment for anxiety, depression and emotion regulation, (3) psychotropic medication treatment for anxiety, depression and emotion regulation, and (4) parenting programs.

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Treatments that are more specialised (e.g. early intervention programs for young children with autism spectrum disorder or interventions for highly traumatised children) would be provided in a limited number of locations. Because these locations would be networked across the country, those with specialised capabilities will (1) support other locations or other service providers to directly help the child/family, and/or (2) support the child/family directly via face to face, video or phone, depending on the nature of the support to be provided. The referral process between the locations with specialist services and those with more general services will be managed by staff, including outreach to children and families to ensure that there is continuity of care. This model will therefore support the primary care workforce by providing a centralised referral option for assessment and treatment of both the child and family.

It is envisaged that implementation of this model would emerge out of and extend current public health services, rather than creating something entirely new. This might involve quarantining (and increasing) some of the resourcing currently allocated to CAMHS and child development services to focus on children up to age 12 years and their families. However, in many areas that experience a shortage of existing child mental health services or health services generally, establishing an integrated model would require additional services.

This model would permit children with less severe symptoms to be seen earlier than is currently happening in CAMHS, and those who are struggling or unwell would likely be seen earlier. The current CAMHS model means resourcing is absorbed by acute crisis management of older teens, which contributes to a relentlessly high-risk client load for staff and subsequent staff burnout.

This model would also bring together child development services and child and youth mental health services, which currently tend to be siloed, delivering the collaborative/multi-disciplinary care that is both critical and best practice for children. The multi-disciplinary centralised model of service delivery mirrors the holistic approach taken by Aboriginal Community Controlled Health Organisations (ACCHOs).

The benefit of incorporating telehealth services means that children and families are still able to access professionals where face-to-face service delivery is not possible. Noting that, in rural and remote areas and for families with limited financial resources, this needs to be accompanied by physical spaces in communities (e.g. community centres, GP clinics, libraries or school welfare coordinator offices) where telehealth services can be accessed with support. This is essential to mitigate barriers, including limited internet access or quality, affordability of data and internet enabled devices and an unsuitable home environment due to safety or privacy issues.
To ensure that implementation of this model actually does improve the mental health of children and their parents, and in order to create a continuous process of further improvement, research and training should be embedded into practice from the start (see Focus Area 4).

Actions 2.1

a. Build on and promote existing online navigational tools (e.g. HealthPathways) to enable both providers and community members to find the most appropriate locally available supports for children struggling with their mental health.

b. Review people's experience of transitions between services (including across jurisdictions and sectors) and redesign processes to ensure children and families experience optimal transition of care.

c. Establish model of integrated child and family care (see Box 3) networked across Australia that provides holistic assessment and treatment for children 0-12 years old and their families.

Objective 2.2 Collaborative care

To effectively support a child's mental health when they are struggling, a range of people are likely to be required to help, including medical professionals, allied health professionals, educators and families. Coordination between these groups is needed, to ensure all partners (including children, parents and carers) can agree on the plan for the child and know what their role is to deliver it.

While there is an acknowledgement of the **need for better coordination and integration of services**, it can be very challenging to put into practice at a policy, planning and service delivery level.[74] There is often a lack of clarity as to exactly what integrated service delivery means, and what it is intended to achieve,[75] with confusion about terminology so that coordination, collaboration and integration are often used interchangeably (see **Box 4**). There are also currently limited arrangements to enable a coordinated approach to care.

Box 4: Definitions of care coordination.

Care coordination has many labels, but all models and related concepts share common elements[76]:

1. Numerous participants are typically involved in care coordination;
2. Coordination is necessary when participants are dependent upon each other to carry out disparate activities in a child's care;
3. In order to carry out these activities in a coordinated way, each participant needs adequate knowledge about their own and others' roles, and available resources;
4. In order to manage all required care activities, participants rely on exchange of information; and
5. Integration of care activities has the goal of facilitating appropriate delivery of health care services.

The most frequently used terms are coordinated care, shared care, collaborative care and integrated care. **Integrated care** implies that care reflects the whole of a person's physical and mental health needs, across providers in primary care, community and hospital settings.[77] **Collaborative, shared, or coordinated care** is a model that relies on multiple service providers communicating about the child's diagnosis and treatment, often via shared care plans led by a primary care provider.[78]

Service delivery integration can occur at a number of levels. In the first instance professionals from different agencies and service can create informal networks – this type of collaboration might facilitate discussion about patients and shared planning of intervention and should be a bare minimum to expect of the service system. Then follow increasing levels of coordination and integration – more formal collaborative networks, common records, sharing of staff, more flexible governance arrangements, all the way through to true integration. At its optimal, this would involve co-location of a number of different services at the one site and include a shared vision with single governance arrangement and management. In addition, processes such as staff training, decisions about resources, record keeping, triage and assessment, and planning would all be integrated.

However, co-location of services does not always guarantee improved coordination. Agencies and services can operate from the same physical site and have minimal or no collaboration. Conversely there can be high levels of collaboration and coordination amongst services that are not co-located, though this type of 'virtual integration' poses particular challenges, especially if services are widely separated geographically. **Colocation certainly does facilitate better linkages and improved collaboration** between agencies and services.[75]

While the focus of integration is usually on the system of services for children and families, it is unlikely that sustained and effective integration will occur without some sort of effort to **improve coordination and collaboration at a policy and planning level**.[79] This is based on the premise that the wellbeing of children is beyond the responsibility of any single government department. Policy and planning need to be integrated across government portfolios, departments and agencies, and

efforts made to coordinate federal and state resource allocation, programs and services. Results from such efforts in the past suggest that this will be an ongoing challenge.

The importance of collaborative care is highlighted for **children with complex concerns who need to be seen by a number of agencies** to get a good understanding of their issues. For example, Attention Deficit Hyperactivity Disorder (ADHD) and learning problems can co-occur but attention problems can also be a consequence of learning problems, as it is difficult to pay attention when you don't understand what a teacher is talking about. To tease this out, both a psychologist and a child psychiatrist or paediatrician may sometimes need to see the child. Where a child has complex issues there may be numerous assessments needed (e.g. psychology, psychiatry, speech pathology, occupational therapy). Currently, when these assessments are done in the private setting there is rarely someone available to draw all the information together for a child and their family.

Multidisciplinary case conferencing is one way of connecting all the people involved in a child's care. It facilitates communication between the providers and gives an opportunity for the professionals, parents/carers and sometimes the child themselves to discuss what is needed and who is responsible for each component of care. Medicare funds case conferencing for people with chronic and complex care needs, as long as it involves a GP and at least two other health or community care providers (e.g. psychologists, social workers, speech pathologists).[80] However, only the GP is able to claim payment for case conferencing, which means families must rely on the goodwill of the community care providers to participate 'pro bono' (action 2.2.a). For children and families with complex needs, **care coordination is a critical ingredient of evidence-based care** and should be funded appropriately (action 2.4.a).

Collaborative care also means involvement of parents and carers. Parents and carers want to understand how they can best support their child. Uncertainty about what they should do can lead to additional worry.[30] **Families may need guidance on how they should respond when their child is struggling**, or how they can help create an environment that enables the child to flourish. This type of information could be provided by the service providers supporting the child. However, Better Access services (i.e. Medicare-funded) do not allow health professionals to claim (i.e. be paid) for consultations with parents without the child present. This limits the delivery of parenting strategies as a key or complementary part of a child's treatment and recovery, as these conversations between a professional and a parent can be harmful if done with the child present.[15] As a result, the current funding system creates **barriers to parents accessing information from services** that would in turn support their child (action 2.2.b).

"My child would be interviewed by themselves. Not once was I asked about our family… seeing children in isolation on a therapy basis is problematic… thinking of parents potentially being their child's greatest strength, to actually feel marginalized in that process is so phenomenally problematic and really probably set us back some years"—Parent / carer of child with a mental illness

Educators, non-government service providers and other community supports also report wanting a better understanding of how they can support a child when they are struggling with their mental health.[81] However, **mental health professionals are not required to provide feedback** to educators or other service providers (other than a GP in some circumstances) despite the pivotal roles these people play in the child's recovery. Feedback could be provided informally (phone call, email) or formally (inclusion as part of a care plan), but there are no consistent expectations or requirements that feedback is provided at all. Current barriers to mental health professionals providing feedback to other supports may include insufficient time, a lack of confidence in working with other sectors (e.g. educators) or a lack of confidence navigating the confidentiality boundaries (action 2.2.c).[82]

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There is also a need for **parental mental health care to be accessible via the same care pathways as for their children** given the high concordance in mental illness across parents and children.[83] A study investigating families with children attending mental health services reported that around 35% of parents had mental health issues themselves.[84] This may be partly due to genetic factors – the heritability of mental illnesses is estimated to be between 40% and 80%,[6] as well as shared environmental effects.[85] Compared to children whose parents did not have mental health symptoms, children of parents who did report mental health struggles had significantly more severe symptoms at follow-up,[86] indicating a vulnerability to poor outcomes for children in these families regardless of the child's specific diagnosis.

"Optimal child health includes all elements of physical health, mental health and family mental health and support."—Parent of a child with mental illness

Not only is it common for parents to struggle with mental health, but addressing parental mental illness is an important part of what child mental health services can do for children. It has been demonstrated that successfully treating maternal depression with medication will result in both lower rates of new diagnoses in children, and remission of the child's own symptoms if they were struggling at their commencement of the parental intervention.[87] This highlights the opportunity for improving *child* mental health at least partly through improving *parent* mental health – that is, **treating a parent struggling with mental illness will benefit them *and* their child** (action 2.2.d). Similarly, services supporting adults who have children should create an opportunity to connect the children with services, if required (action 2.2.e).

Currently, the care for mental illness in children and adults takes place in separate services, with public services inaccessible for parents and carers unless their mental illness is very severe. This means that for the majority of parents with anxiety or depression, treatment is limited to the private sector, which is often associated with significant out-of-pocket costs. Given that families experiencing adverse circumstances (e.g. unemployment) are more likely to struggle with mental illness,[84] many of these **parents cannot afford to seek help and will forego care**,[88] thereby worsening the parent's and the child's prognosis (action 2.2.f). Improving the outcomes of these vulnerable families, starts with **asking parents about their mental health** when they present with their child to an outpatient service, and vice versa. This should include the siblings of the child presenting to services. Despite concerns from clinicians, data collections in outpatient clinics show that routinely asking parents about their own mental health is well accepted by parents.[84]

There is also an opportunity to use the almost universal setting of **workplaces to support the mental health of parents**. Where relevant, this should include programs that incorporate strategies for new parents, especially in the early weeks and months of adjusting to parenting, and during the return to work phase (action 2.2.g).

Things we can build on

In some states and territories early childhood learning services (known as 'children's centres' and 'child and family centres') provide a **range of services across care, education, health, community development activities and family services, tailored to local needs.**[89] This includes regular and occasional care for babies, toddlers and children in the year before school, as well as playgroups, and parenting programs. In some cases, antenatal services are also available, and there is an allied health program (delivered by speech pathologists and occupational therapists) that builds capacity of

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centre staff and parents in identifying children from birth to 3 years who are at risk of developmental delay. Centres also have family practitioners who can support vulnerable families and children, including those struggling with issues of domestic and family violence, drug and alcohol use and mental illness. In an evaluation of these services, parents reported that the children's centres had positive impacts on their wellbeing, parenting capacity and parenting practices.[90]

Actions 2.2	
a.	Incentivise all relevant service providers to participate in case conferencing. This could be done by enabling providers of all disciplines to claim the existing case conferencing Medicare item numbers.
b.	Enable service providers to claim Medicare payments for consultations with parents and carers as part of a child's mental health treatment, removing the requirement for the child to be present.
c.	Require mental health professionals to communicate with educators and other service providers about a child's treatment and support plan, with the family's permission and subject to this being deemed clinically appropriate.
d.	Equip child mental health services to identify parents and carers who are struggling with their own mental health and require them to connect those parents and carers with appropriate supports.
e.	Equip adult mental health services to identify any children in their clients' care who need mental health support and require them to connect those children with appropriate supports.
f.	Ensure free or low cost mental health services are accessible to parents and carers with mental illness.
g.	Include content specifically targeting parents in workplace mental health programs, with a particular focus on new parents during the return to work phase.

Objective 2.3 Access and Equity

Many children and families are **unable to access timely treatment.** A long delay in children accessing supports can have a negative impact on the child's outcomes and is contrary to the principles of prevention and early intervention. Problems accessing services could be due to a range of reasons, including high out-of-pocket costs, long waiting lists, some services requiring a diagnosis to access treatment, or unintentionally high severity thresholds simply due to difficulty meeting demand.

The **mental health system generally comprises public services, private services, and some non-government services**. Public services are provided at no cost to families, they are typically designed to cater for children in complex circumstances, but they often have long waitlists and/or high severity thresholds to access a service. Private services are associated with (sometimes high) out-of-pocket expenses, are not designed to manage complex cases, and they can also have long waitlists. Non-government services often provide specific programs for particular cohorts of children and/or families, which can mean many don't meet criteria for access because of geographic boundary limits, specific diagnosis (or lack thereof), age etc.

"When I was in year three or two, I had a play therapist and a few months into the year I stopped going and I didn't understand why, apparently I didn't have the funding. I thought it was helping"—Youth participant with experience of mental illness

Out-of-pocket costs mean that an individual service is either ineligible or only partially covered by a relevant Medicare item. Out-of-pocket costs for Australians seeking mental health services are known to be relatively high, and people with chronic conditions are more likely to forego care because of the associated costs.[88] Adults with depression, anxiety and other mental health conditions are 7 times more likely to forego care due to cost compared to people with no health condition (action 2.2.f).[88]

"The thing that I found the most troubling was the financial side of it… I have been seeking therapy for four years now and I've only just realised that my psychologist outside of school, I can't see her anymore because I don't have the funding… I don't have enough money to go see her"—Young person with experience of mental illness

For many families, the cost of private services is prohibitive, but they do not meet severity thresholds to access the free public services. There is a **lack of capacity within public mental health services** for those who currently need them. CAMHS must triage based on severity and a lack of capacity results in services being directed to older children and adolescents with acute (i.e. crisis) presentations.[15] This makes it difficult for families to identify an affordable alternative service for a child with lower level needs. Children are often also placed on long waitlists to access publicly funded paediatric services, with some children turned away when services have no capacity (action 2.3.a). Being placed on waitlists and turned away from services can be incredibly disheartening for children and families, as well as being detrimental to their mental health and recovery. This can leave children in limbo, delaying or preventing access to the supports they require.

"The worst thing is just the waiting and being turned away"—Young person with experience of mental illness

Access to mental health care can also be improved by having the onus on the service system (not just families) to **make space for conversations about children's mental health and offer supported access to services**. Service providers should make the most of (often incidental) opportunities to ask parents directly if they have concerns about their child's behaviour or development. Increased training and additional professional support for GPs and paediatricians on how to best help families and children who are struggling could result in a more efficient way to provide these families with the support they need. This would help them be more competent and confident in providing interim responses and enabling care planning processes to occur (action 2.3.b). Similarly, services that work with children experiencing difficulties with language, learning or other aspects of development provide an opportunity to discuss any concerns about mental health and connect with services where appropriate.

Face-to-face services are generally the preferred service delivery model – this approach is familiar for most people and it enables building of rapport with health professionals.[91] However, **access to face-to-face services is not possible for everyone**, especially for families living in regional and remote areas where there may be no professionals with the required skills in child mental health. To access services, children and parents may need to travel long distances at their own cost, and at the expense of missing school or work and spending time away from the rest of their family and community (action 2.3.c).[91]

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One approach to support increased face to face care, is to **equip primary care services with the appropriate resourcing and training**, so that they have sufficient capacity and expertise to support child mental health locally. By increasing the ability of primary care to support children who are struggling with less acute but more common difficulties, referrals to specialist services can be reduced and equity and accessibility for those outside metropolitan areas is likely to be increased.

Telehealth services are also an important adjunct to face-to-face service delivery. However, there are currently restrictions on who can access telehealth services (i.e. specific postcodes) and which professionals can deliver services (e.g. nurse practitioners cannot access Medicare-funded telehealth items). Given the success of this measure during the COVID-19 pandemic, it is an optimal time to continue to build expertise in delivering telehealth services effectively, as well as expanding their availability. There is growing confidence between service providers and service users with this modality of care, and a recent senate committee recommended that telehealth items introduced during the pandemic become permanent (action 2.3.d).[92] Telehealth should also be utilised to support primary care providers and those who are more geographically isolated through activities such as supervision, professional advice and shared care.

Many services also lack **cultural accessibility** in that they are not acceptable or appropriate for children and families who do not identify with the dominant culture. This may include those from culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities. Barriers can be both cultural and structural, including discomfort with the physical environment of the service or a lack of literacy about how health services typically operate (e.g. appointments, payments, referrals, roles of different providers and overlapping interventions).

Incorrect assumptions can lead to unrealistic expectations about the extent to which people will be knowledgeable about medical care models and styles of engagement.[93] To avoid these pitfalls, it is crucial that services be designed, delivered and evaluated with significant involvement from the people who are intended users of the services (actions 2.3.e and 2.3.f).[94,95] For Aboriginal and Torres Strait Islander communities, it is critical that their children and families are able to access support through ACCHOs.

"Accountability around responding to the needs of diverse communities… that is often something that is missing"—Professional from migrant and refugee services

More broadly, it is crucial that services be **designed in a way that makes children and families feel safe and comfortable**. Children and families are not commonly involved in the co-design of services, which means they miss out on opportunities to contribute to developing services that are inviting and acceptable to them. Young people report experiences of services not always understanding their perspectives – for example, the purpose and function of therapy is not always explained in a way that makes children feel safe to openly share their innermost thoughts and feelings.[30] Children may not be given a choice about how they can engage with services (e.g. non-verbal activities as well as talking), or they might feel that they are not given enough opportunity to build trust with a professional before being expected to engage (action 2.3.e).

"They didn't really make a point of trying to explain how therapy would work. All I knew about it was from leaflets and the movies, and movies are probably the worst way to learn about therapy… I was expecting like Enid Blyton where if a kid was bad, they would get sent off to boarding school or a medical facility… so I was actively terrified of telling a medical professional anything"—Young person with experience of mental illness

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Things we can build on

Many families have benefited from **access to telehealth services**, with the use and acceptance of these services increasing during the COVID-19 pandemic. Telehealth services have been used in rural and remote areas for some time now. A recent systematic review found that patients and caregivers were generally satisfied with telehealth services, including in the domains of system experience, information sharing and consumer focus.[91] Even young children have been able to access services successfully through this model (see **Box 5**). While telehealth services are not the optimal solution for all families, they can play a useful role increasing the accessibility of professional services and advice for those whose access to local professionals may be limited.

The **NSW Child and Adolescent Psychological Telemedicine Outreach Services** (CAPTOS) has been in operation since 1996. The function of the service is to provide psychological and psychiatric advice on assessment and treatment of children in rural areas to local clinicians. It also serves to support clinical education and supervision for non-specialist rural clinicians.[96] Under this model funding is controlled by the rural provider rather than centrally by the specialist service (action 2.3.g). An initial evaluation focused on user satisfaction found that 95% of rural families and clinicians using the service were highly satisfied, and subsequently further services including telenursing, professional skills development, sabbaticals for rural clinicians and clinical skills workshops were developed.[97]

In NSW, a consortium of PHNs have jointly commission the **GP Psychiatry Support Line 2020**.[98] The service is staffed by psychiatrists and is available free to GPs practicing within the associated PHN regions. It has been active since 2019, and can assist with diagnosis, investigation, medication and safety plans to help GPs manage the care of consumers in the community (action 2.3.b).

Box 5: Telehealth services

Mia's* 4-year-old son struggles with anxiety and regularly sees a psychologist along with other health professionals, such as a speech pathologist. When the COVID-19 pandemic prevented her son from being able to see his psychologist in person, they were given the option of consultations through telehealth services. Given how young her son was she was unsure how well he would engage. However, she found it to be more effective than anticipated. Her son was happy to sit at the computer and engage with his psychologist as well as other health professionals.

Mia found that receiving services through this model also had additional benefits that she had not foreseen. She reported that by being able to receive the services at home, this reduced the time and stress of travelling to and from appointments. It also resulted in the opportunity for his psychologist and teacher to meet via video call and discuss opportunities to support her son. She felt that this had enabled her son to receive more integrated care without significantly increasing the costs for their family.

* Name has been changed to protect anonymity

Actions 2.3	
a.	Increase resourcing for public mental health services to support children age 12 and under. Funding should be attached to implementation of the integrated model of child and family care (action 2.1.c)
b.	Provide accessible and affordable training and resources to GPs, paediatricians and other care providers to help them respond to children and families who are struggling.
c.	Implement innovative service delivery models that integrate face-to-face and telehealth consultations, digital interventions, and phone helplines to improve access to services.

d.	Commit to ongoing Medicare funding for telehealth services.
e.	Embed the principles of genuine co-design into the design, delivery and evaluation of all services supporting children and families; actively inviting involvement from the people the service aims to support.
f.	Establish accountability mechanisms (e.g. audit and public reporting) that encourage services to improve their accessibility for children and families, including those from Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.
g.	For programs involving specialists providing advice, education or professional support to rural providers, adopt governance arrangements that make funding dependent on the rural provider's needs being met.

Objective 2.4 Built for complexity

Both health and social services (e.g. child protection) have a role in **ensuring that children and families dealing with complexity are well supported**. This may include where children have intellectual or developmental delay, children whose parents have struggled with their own mental health, children who have experienced the child protection system, and families that have faced significant trauma and adversity. These children and families may be more likely to require support from multiple services, which may include specialised expertise. Children and families with complex needs would benefit from a **nominated care co-ordinator** (action 2.4.a)**.** This role would support families to navigate the service system, and to liaise with the clinicians and educators involved in a child's care.

A specific group of children with the most complex needs are **children under the care of the State**, including those in contact with the justice system. These children are likely to have been exposed to trauma that has led them to enter State care and are also at risk of experiencing trauma within the system. Children who have experienced the child protection system are twice as likely to experience mental illness, and children who have experienced out-of-home care are five times more likely.[99] Higher rates of mental illness are also observed in children who have experienced youth detention.[100]

These children are likely to benefit the most from high quality, well-coordinated mental health supports. **Currently, these children are more likely to be turned away from services than other children as their needs can be more complex**, and services report that they do not have the capacity to cater for them.[101] This can mean that children in State care are unable to access health and wellbeing support until their mental illness has severely escalated. Therefore, children under the care of the State need to be supported as a priority in order for any mental health strategy to have maximum impact (action 2.4.b).

"The starting point should be that children in out-of-home care receive the same, if not better services to everyone else… But the more challenges for the young person, the less likely they are to receive services in a timely manner… There's a disconnect between what should be done and what actually happens on the ground"—Professional from out-of-home care and child protection sector

Governments have an **increased responsibility to serve this population of children** who are directly under their care. While child protection systems are focused on making sure the child is safe, this is not enough. Children in out-of-home care remain at very high risk for a range of health,

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developmental and mental health problems over the long term. International models use the term 'corporate parent' to describe the additional responsibility that governments have for looking after the health and wellbeing of children in out-of-home care.[102] Given the range of difficulties these children often face, all government portfolios should play a role in supporting them and improving their wellbeing (action 2.4.c).

"What's needed is more of a model such as they have in Scotland… they have the principle that every branch of government at every level has to take responsibility for young people in care… that becomes a holistic view… [children in care] are not hived off to one area or another, everybody is responsible in some way"—Professional from out-of-home care and child protection sector

Children with a **disability or a chronic illness are at significantly higher risk of having mental health issues** than children without a disability. Those with an intellectual disability are up to four times more likely to have a diagnosable mental illness.[103] In addition to the disability itself, the mental illness has an impact on school participation, relationships, family functioning and long term outlook, as the mental health problems may persist throughout the life course.[104] The combination of disability and chronic illness places these children at particular risk,[22] with studies finding an approximate doubling of risk of mental illness for children with chronic health conditions, and these are likely to persist into adolescence.[105] Furthermore, there are indications that anxiety symptoms can worsen the outcomes of physical illnesses (action 2.4.d).[106]

"As soon as someone has some kind of disability, their mental health is viewed differently, and it can mean very poor outcomes… it can mean early intervention isn't made possible around mental health because it's so focused on disability"—Parent / carer of child with mental illness

This increase in risk for children with disability has implications for the way that the National Disability Insurance Scheme (NDIS) is structured and functions, and **all disability services need to be aware of and address the likelihood of and potential for associated mental illness**. At present, the NDIS has an Early Childhood Early Intervention approach which supports children aged under 7 years who have a developmental delay or disability and their families and carers.[107] This approach is administered by an Early Childhood Partner who develops a plan for each child including referral to local supports.[108]

The National Roundtable on Mental Health of people with intellectual disability recommended development of greater workforce knowledge and skills in prevention and timely intervention for those who need mental health support.[109] For children, this may include community led interventions, such as whole of school approach to creating an inclusive culture, or more targeted interventions such as opportunities for students to practice complex social skills in stepwise fashion.[110] Within health and social services, **there are barriers such as lack of investment and research into mental health assessment tools and effective treatment approaches for this population**, along with insufficient (and under-funding of) specialist services that offer expertise in both mental health and intellectual disability (action 2.4.d).[111]

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Similar challenges exist for children with neurodevelopmental disorders[viii], with **increasing access issues for children requiring a complex autism assessment by a multidisciplinary team.** It is estimated that 1-2.5% of Australian children experience some form of Autism Spectrum Disorder (ASD).[112] Families of children with ASD experience higher rates of mental health struggles, and children with undiagnosed or poorly treated ASD often become increasingly anxious and depressed with age.

ACCHOs are skilled at **adapting and designing services to meet the often complex needs of their specific communities**. However, available funding structures do not always support these services to be delivered in the way the community would like. Mainstream funding frameworks can be rigid and require demonstration of specific outputs (e.g. number of 50-minute therapy sessions) that may not be relevant to the nature of the service model the community requires (action 2.4.e).

Things we can build on

The **National Standards for out-of-home care require** that children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way. This means that the child or young person's needs are identified in a preliminary health check upon entering care, in order to receive specialised services.[113] The National Clinical Assessment Framework for Children and Young People in out-of-home care supports the implementation of the National Standards. The Framework provides age appropriate (less than 1, 1-5 years, 6-11 years) assessment elements, including measures across cognitive and language development, behavioural and emotional development, mental and physical health and health history.[114]

In the area of youth justice, the **Youth on Track scheme in NSW** has been effective in supporting children aged 10-17 years who are at risk of becoming entrenched in the juvenile justice system.[115] The program involves providing targeted support for children and families, including family interventions, behavioural interventions and strategies for engaging children with education. Children and families may be referred to this program through schools or by police (action 2.4.f). Elements of the program which were found to be particularly effective included the focus on early intervention, the holistic and tailored approach (including working with families), the trained and skilled professionals, and collaboration with other services.[115] The program has been found to contribute to positive attitudinal and behavioural changes in young people referred to the scheme, as well as changes in lifestyle to reduce the risk of offending amongst the youth, such as enrolling in vocational training and developing new friendships or community connections. A version of the scheme '**Getting on Track in Time – Got It!**' targeting younger children (aged 5-8) displaying behavioural concerns and conduct problems is also delivered in NSW schools.[116]

Actions 2.4

a. Provide specific funding for care coordination to be available to children and families with complex needs.

[viii] **Neurodevelopmental disorders** are characterised by developmental deficits that interfere with personal, social, academic, or occupational functioning. These may range from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence. They are considered to be a subset of mental illnesses.

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b.	Require relevant services to give priority access to children who are in State care.
c.	Require all government departments to outline and regularly report on what they do to support children in State care.
d.	Require relevant services to outline and regularly report on what they do to ensure they are accessible and effective for children with physical or intellectual disability or neurodevelopment disorders.
e.	Child and family mental health and wellbeing supports for Aboriginal and Torres Strait Islander communities should be delivered by Aboriginal Community Controlled Organisations wherever possible, with activity and outcome measures to be collaboratively determined between the funder, service provider and the community to ensure they are appropriate.
f.	Build on holistic support models for children who have had contact with the justice system or are at risk of coming in contact with the justice system.

Objective 2.5 Skilled workforce

Staff working across primary care, non-government services, the private sector, and public mental health come from a wide range of disciplines and training backgrounds. As a result, **the quality of care children and families receive is variable**. This is unacceptable – the quality of care a child or family receives should not depend on which staff member they happen to see.

Child and family mental health is considered an area of specialty that receives minimal attention in the majority of training courses and there are limited opportunities to gain expertise in child mental health through on-the-job training (actions 2.5.a and 2.5.b). There is a shortage of publicly funded positions for a range of health disciplines, which has flow-on effects to training capacity in the public system and inadvertently encourages graduates to directly enter the private system. This limits opportunity to build child and families expertise in public (i.e. free or low-cost) service settings (action 2.5.c).

"The chance of getting a good mental health professional who is able to work with children is like finding hen's teeth… we don't have a group of professionals who've got the specialised practice that we can bring to a cohort of really traumatised young people"—Professional from out-of-home care and child protection sector

As for many other health services, **there is a dearth of mental health professionals for children in rural and remote areas**.[68] The provision of training and education for child mental health professionals is largely only available in metropolitan areas. Supports for rural mental health professionals (training, workforce and pastoral) are lacking, adding to the burden experienced by professionals who are located remotely. Market failure in rural and remote areas also results in private practitioners being drawn into larger metropolitan areas, diminishing the supply of desperately needed child mental health professionals in more remote communities (action 2.5.d). [68]

"We are a rural or remote site… we had a child… and we believed they needed psychological support and we exhausted all of the different avenues and there was nothing that anyone could offer ... the child was four and taking medication. We didn't know how we should support the carer and the child and still don't know how we should do that"—Education representative working in a remote area

For those who work in the public health system, consistently dealing with more complex 'crisis' cases can result in **clinician burn-out and subsequent staff turnover**. As a result, services often find that senior practitioners move to the private sector where they can work with a more varied mix of clients. While a number of system reforms are required to address these issues, a key focus of this Strategy is to deliver better interventions, earlier. It is anticipated that this would in turn reduce the unrelenting demand on public mental health services and enable them to provide earlier interventions.

A skilled mental health workforce is also one that has **strong cultural competence**. Lack of Indigenous health workers in services leads to underuse of services, while increased cultural understanding and culturally responsive service delivery increases access and frequency of visits (action 2.5.e).[117]

Things we can build on

In some cases, **rural training pathways** that include an element of focus on mental health already exist. For example, all Fellows of the Australian College of Rural and Remote Medicine undertake one year of Advanced Specialist Training as part of their core training. They can elect which discipline they spend their Advanced year on, with mental health and paediatrics as one option.[118] However, unlike for some specialisations (e.g. obstetrics or anaesthesia), professionals with additional mental health specialisations are not remunerated for these advanced skills. This currently acts as a deterrent to professionals taking the mental health pathway (action 2.5.b).

The ***Extension for Community Healthcare Outcomes*** **(ECHO)** model has been used to effectively build the capacity of primary care clinicians to manage complex health issues in areas where there may be an absence of specialist expertise.[119] In this model, professionals meet on an ongoing basis through telehealth platforms to enable specialists to share knowledge and advice with primary care clinicians in local communities. Use of the ECHO model for providing mental health management in primary care has been found to increase knowledge and self-efficacy and reduce feelings of professional isolations amongst rural health professionals.[120] This is particularly important in rural areas, where ongoing supervision or professional support is often lacking.

Communities of practice is another a model for sharing ideas, insights and strategies between professionals with involvement, interest, or concerns in a particular area of practice. These communities bring together professionals from different disciplines and organisations and have been used in the healthcare sector to help change and improve practice (action 2.5.f).[121,122]

The **Royal Far West model of rural and remote program and service delivery** for children offers multidisciplinary care both face to face and via video conferencing.[123] They offer paediatrics, psychiatry, psychology, speech therapy, occupational therapy and social work services, and over half of their services are already delivered by telecare as part of their paediatric developmental program. If attending face to face, children and their families attend a free week-long residential program that comprises assessment, diagnosis, review and treatment. Continued schooling is available on site for children and their siblings, with technology-based outreach learning and literacy programs available for 'telecare' program participants.

Professional training and development are being offered through the ***Emerging Minds: National Workforce Centre for Child Mental Health*** **project**. The project aims to build the capacity of

organisations and professionals who work with children (0-12 years) and families to identify, assess and support children at risk of mental health difficulties. Courses are free and available online, targeted at professionals in health, social or community services. Courses are staggered in their complexity from introductory modules through to evidence-based practice courses which teach hands on skills.[124]

The **National Mental Health Service Planning Framework - Planning Support Tool**, is a population based planning model that provides resource estimates to guide mental health service planning.[125] The tool allows users to estimate the needed and expected demand for mental health care and the level and mix of mental health services required for a given population. This is turn should guide the relevant local workforce projections (action 2.5.g).

Actions 2.5
a. Increase requirements for early career training in child and family mental health for all relevant service providers.
b. Incentivise existing service providers (including GPs, maternal child and family health nurses and allied health) to complete training in children and family mental health assessment and treatment.
c. Require public mental health services to act as training facilities for new graduates through designated training places and funding of supervision time.
d. Create and incentivise training opportunities for mental health professionals (e.g. psychologists and psychiatrists) to work in regional and remote areas.
e. Develop cultural understanding amongst health professionals to work safely and effectively with Aboriginal and Torres Strait Islanders children and families.
f. Build on existing models of supervision and case consultation for private practitioners using a peer support/supervision model.
g. Develop workforce projections in the public sector based on evidence and epidemiology and use these to inform further recommendations.

The below table outlines some proposed **indicators of change**. If the objectives of this focus area are realised, we would expect to see improvements in the below.

Focus Area 2: Service System – indicators of change	
2.1	The ease of service navigation for both service providers and the community, including transition between services.
2.2	Extent to which children and parents are able to receive holistic, low cost care, regardless of which service they first present to.
2.3	Rate at which case conferencing between service providers occurs, and frequency of communication with educators and other service providers about a child's treatment and support plan.
2.4	Increase in accessibility due to funding for innovative models of service delivery, noting that governance arrangements should allow funding to be controlled based on location of services, not the providers.
2.5	Increase in accessibility due to embedding of co-design principles in the design, delivery and evaluation of services, particularly for diverse communities.

2.6	Effectiveness and accessibility of services for children with physical or intellectual disability or neurodevelopment disorders.
2.6	Extent to which children and families who have complex needs, including involvement in state care or contact with the justice system, receive priority access and well co-ordinated care.
2.7	Increase in numbers of service providers with training in child and family mental health assessment and treatment, with associated training places in public settings and rural and remote areas, based on evidence informed workforce projections.
2.8	Level of cultural understanding amongst health professionals to work safely with Aboriginal and Torres Strait Islander children and families, with priority for delivery of supports via Aboriginal Community Controlled Organisations.

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Focus Area 3: Education Settings

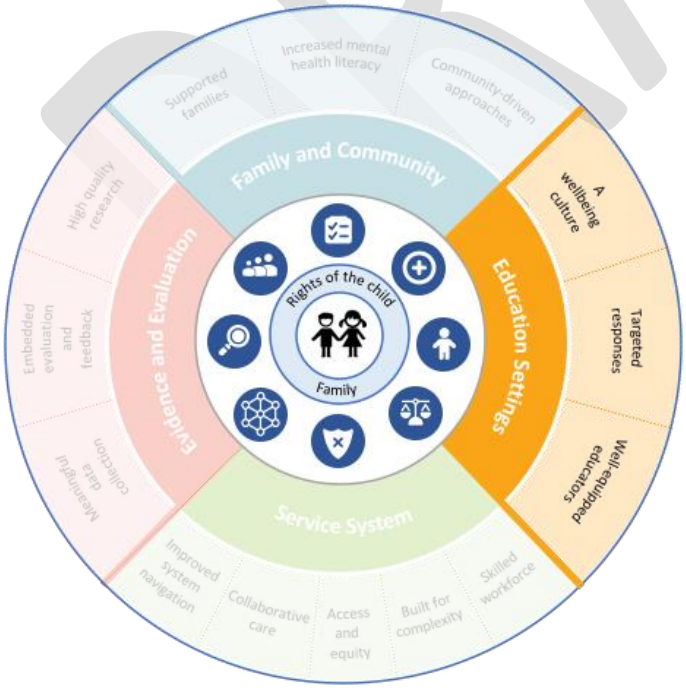
This section outlines **key issues and recommendations in relation to supporting mental health in the education context**, which for the purposes of this Strategy, includes early childhood learning services and primary schools. All educators and education settings have a role to play to promote child mental health and wellbeing, including where a child and family has complex needs. The NMHC recognises that education settings are already doing a considerable amount to support the wellbeing of children. The actions outlined below aim to build on this, with an emphasis on supporting educators in this role, not creating added burden.

Within the education sector, **supporting children's mental health needs to be central to the frameworks and standards** on which the education and early childhood systems are built. Key objectives in this focus area include creating a wellbeing culture; planning for mental health and wellbeing, and engaging, supporting and equipping educators.

Why the educational context is so important.

Education settings provide an ideal environment to **build resilience, support and empower parents and carers, and identify and intervene early** in emerging mental health issues. Especially, as they are a relatively universal, non-stigmatising environment where children can be observed for long periods in multiple contexts.

Education settings are already providing support in many cases. Data from the Young Minds Matter survey (the second Australian Child and Adolescent Survey of Mental Health and Wellbeing) indicate that teachers and other staff provide nearly 20% of students with informal support for behavioural and emotional problems, with staff members suggesting that additional help was needed in around 40% of cases. In addition, 11.5% of students have used a school-based service for support in the last 12 months, with 22.6% who used a health services having been referred by the school.[16]



Education objectives:

3.1. A wellbeing culture

3.2. Targeted responses

3.3. Well-equipped educators

Consideration of early childhood education is an important aspect of this Strategy given there are **lifelong benefits of early childhood education** to individual children and families. Early childhood

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education helps children's cognitive, social and emotional development,[126] with greatest benefits for vulnerable or disadvantaged children.[46] Quality early childhood education can help reduce the chances of these children being left behind, with flow on effects on learning and academic progress, school completion, and employment and income outcomes.[126] Quality early childhood education also has long term economic benefits through increased productivity and reduced need for spending on remedial education, justice and health services. There are also immediate economic benefits from parents, particularly mothers, being able to increase their participation in the workforce.[127] One Australian report found that the return on investment of offering universal early childhood education was 103%.[126]

Objective 3.1 A wellbeing culture

Educational settings provide a **unique and almost universal opportunity for promoting child mental health and wellbeing** with 90% of eligible children enrolled in a pre-school program the year before full time school, and attendance rates of at least 90% in the primary school years.[3] Given this opportunity, it is imperative that all educational settings play their role in promoting mental health and wellbeing in their students. For children and families who are not engaged with schooling, alternative strategies are needed (objective 1.1).

Children spend large proportions of their days in the classroom and the playground, and it is where much of their social interaction with peers occurs. However, there is currently **wide variation between schools and early childhood learning services in the culture around mental health**. Schools vary in terms of how regularly mental health is spoken about, how accepted and easy it is to access support, and educators' awareness and understanding of mental health. Schools provide opportunities to discuss trusting relationships, kindness, respect, managing challenges and bouncing back, and how to look after mental health with good food, sleep, activities and hobbies. Schools could address these issues, as well as the challenges of the digital environment and screens, more systematically and consistently.

Some school and early childhood service have **policies and procedures that contribute to stigma and a negative culture around mental health**. For example, young people report feeling 'marked out' for accessing support services through their school. This was because the process by which students were referred to or accessed supports was not managed discretely, and the students lacked control in the process. Children and young people reported that this made many feel uncomfortable to seek help in the school environment (see **Box 6**). Policies and procedures should be reviewed to address potentially stigmatising elements (action 3.1.a).

"I only got told there was a school counsellor when I was getting really badly bullied… the school counsellor wouldn't introduce herself. She would come into the classroom while everyone was working and say 'can I see [you], I want to have a session'... that was probably the worst thing to do" – Young person with experience of mental illness

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Box 6: Differing approaches to mental health and wellbeing in schools

Annie* reported having two very different experiences with mental health and wellbeing support at the two schools she had attended.

She explained that at her primary school, she had not realised that they had counselling services available for most of the time she was at the school and that mental health had generally not been talked about. She reported that it was only once she started being severely bullied that she was directed to the school counsellor. Annie reported that when the counsellor wanted to have a session with her, the counsellor would walk into the classroom and ask Annie in front of the whole class which made her uncomfortable and embarrassed.

Annie reported a very different experience at her new school. She explained that there was a mental health team at the school that the students all knew about and it was made clear there was a welfare counsellor they could see if needed. She reported that mental health was something that was spoken about throughout the school, including at school assemblies. Discussing mental health was normalised and students would encourage each other to seek help and speak to the counsellor if they were struggling. Annie reported that the teachers were also proactive at checking in with students and asking if they were okay when they were looking upset.

* Name has been changed to protect anonymity

Educators, particularly in school settings, are working within a busy curriculum, and mental health and wellbeing competes against a number of different public health areas for space and attention. Some schools have wellbeing teams, school nurses, chaplains or other staff who have a dedicated role in supporting children's wellbeing. However, there are **not always dedicated staff to progress mental health and wellbeing initiatives** and to ensure that the early childhood service (action 3.1.b) or school (action 3.1.c) is providing the best possible support for students.

The way education settings approach mental health and wellbeing contributes significantly to whether children access supports when needed. Both children and families describe wanting education settings to cultivate **open and supportive conversations about mental health and wellbeing** so that peers can encourage each other to seek support if they notice a friend struggling. This may be achieved using formal and informal opportunities e.g. through assemblies, awareness days, or student projects / activities (action 3.1.d).

"[The school] does lots of discussion around mental health to the point where it's quite ok to talk about it amongst their friends'"—Parent / carer of a child with mental illness

Proactive promotion of resources and supports to children and families is also key, including those available through the school, as well as external options. This could be achieved through orientation processes, assemblies, newsletters, or dedicated information sessions (action 3.1.e).

Schools are also an **important avenue for enabling migrant, refugee and Aboriginal and Torres Strait Islander families to access mental health and wellbeing information,** given that almost all children and families come into contact with them. Schools must continue to create and maintain a supportive environment for promoting the wellbeing of all students (action 3.1.f). This can be achieved via specific programs such as Think Equal, which have been designed to promote social and emotional learning and to reduce gender inequality, racism and other divisive behaviours via increasing compassion, empathy and critical thinking.[128]

There is also further opportunity to **promote early social and emotional development in early childhood learning services**. A 2018 review of the quality of evidence for preschool programs to support social and emotional skills found four programs with high quality evidence of impacts. Positive outcomes included impact on social behaviours, conduct problems, emotional distress and parent-child interactions.[89] Accredited social and emotional wellbeing programs which are appropriate for pre-school age children need to be delivered through early childhood education settings, including programs that assist children to develop skills to relate with other peers and regulate their emotions (action 3.1.g). Programs for school aged children should also be available **after school and during school holidays** to provide respite to parents and to help children with emotional wellbeing, loneliness, and self-worth (action 3.1.i).

Things we can build on

The **Alice Springs (Mparntwe) Education Declaration** (signed in Dec 2019),[129] sets out the national vision for education and the commitment of Australian Governments to improving educational outcomes. The Declaration places students at the centre of their education by emphasising the importance of meeting the individual needs of all learners, and outlines education's role in supporting the wellbeing, mental health and resilience of young people.

The **National Quality Standard (NQS)** sets a high national benchmark for early childhood education and care and outside school hours care services in Australia. Under the National Law and Regulations, all early childhood education and care services are required to base their educational program on an approved learning framework. Belonging, Being and Becoming: The Early Years Learning Framework for Australia is the approved learning framework under the NQS for young children from birth to five years of age. My Time, Our Place: Framework for School Age Care in Australia is the approved learning framework under the NQS for school age children. These frameworks encompass social and emotional wellbeing and development outcomes.

Be You is a universal mental health and wellbeing program for children that can be delivered in schools and early childhood learning services. It was established through the integration of a number of Australian Government funded programs, combining knowledge and expertise gained from these over the years. Be You provides a common framework with evidenced-based information, professional advice and support for educators.[130] Be You is also delivering whole-of-team professional learning to more than 3,000 early childhood learning services, aiming to reach all 15,000 services eventually. Be You is being implemented in 70% of schools nationally.

The **Student Wellbeing Hub** is an online platform that aims is to support Australian schools to promote student wellbeing, safety, and positive relationships.[131] The Hub is underpinned by the Australian Student Wellbeing Framework (2018). The Hub provides high quality, age-appropriate information and resources targeted specifically to educators, parents and students. The educator area contains free, self-paced and certificated professional learning courses on a range of key topics for schools. The parent area contains advice, information and guides to support them navigate their children's journey through school. Students can access games, quizzes and information about issues most important to them.

A **Mental Health in Primary Schools Pilot (MHiPS)** is a project commenced in a number of Victorian schools in 2020.[132] Based on a needs analysis, a literature review, and discussions with key stakeholders, a Mental Health and Wellbeing Coordinator (MHWC) role was designed. The MHWC,

who is from an education background, is tasked with building the capability of the whole school with regard to mental health and wellbeing, providing support to staff to better identify and support students with mental health needs, establishing clear pathways for referral for students requiring assessment and intervention, monitoring and evaluating student progress, and promoting connections between the education and health sectors. To provide the MHWCs with training appropriate for the role, a 3-day intensive, online synchronous training program was delivered. MHWCs are then supported throughout the year with community of practice sessions and ongoing supervision, which aim to build the practical skills of the trainees along with giving them space to reflect on the real world implementation of their learnings.

Targeted programs for **children who have experienced significant change or loss in their lives** are based on the principles of normalising emotions in response to difficult experiences. They help children to understand their feelings, learn skills that help them adapt, and develop reciprocal friendships which reduce isolation - '*I'm not the only one who this has happened to'*. Evaluations of this model of psychoeducation coupled with peer support have found that the majority of children respond positively to the learning outcomes, including increased confidence in seeking support, general feelings of coping better and being able to talk about feelings more freely.[133]

Actions 3.1	
a.	Conduct thorough reviews of school and early childhood policies and processes, looking for opportunities to reduce possible stigma and discrimination.
b.	Identify senior staff within early childhood learning services to be responsible for planning and coordinating wellbeing activities for their children/students.
c.	Employ wellbeing coordinators in each primary school to be responsible for (1) planning and coordinating wellbeing activities for the students, and (2) maintaining knowledge of and relationships with locally available and online supports. These positions should be funded on an ongoing basis.
d.	Identify opportunities to incorporate conversations about mental health and wellbeing into the school or early childhood daily routines, with the expectation that all staff and students have the opportunity to contribute to these discussions.
e.	Promote evidence-based, locally available or online supports and services to children and families through schools and early childhood learning services.
f.	Outline and regularly report on how schools and early childhood learning services are improving on current levels of cultural accessibility for children who identify as Aboriginal or Torres Strait Islander or from culturally and linguistically diverse backgrounds.
g.	Implement evidence-based wellbeing programs within schools and early childhood learning services, with support from existing initiatives such as Be You.
h.	Increase accessible activities after school and during school holidays to provide respite for parents and children.

Objective 3.2 Targeted responses

All early childhood learning services and schools should have **a wellbeing plan in place for their students**, with policies and processes developed or adapted to address the gaps in support identified as part of wellbeing planning (action 3.2.a). This should be based on an audit of policies and processes to examine whether they are effective in delivering wellbeing outcomes for students. For early childhood learning services, this could be through adding mental health to Quality Improvement Plans to avoid duplication in planning processes. Flexible funding must be available to schools and early childhood learning services for the purpose of improving policies and processes and ensuring high fidelity program implementation. This funding should be allocated based on need (action 3.2.b).

At primary school stage, a common issue raised by both parents and educators relates to bullying, which has been the subject of much research. There is evidence that children who are bullied by peers have an increased risk of problems in young adulthood including anxiety, depression, self-harm and suicidality.[134] Children can be bullied both inside and outside of the school environment, including online. Schools should **deliver programs to assist with the prevention of bullying and to support healthy peer relationships** (action 3.2.b). However, as is the case with wellbeing programs generally, there is currently a wide variety of programs available for schools, but not all are evidence-based or implemented as intended.[135] Full implementation of programs is often difficult due to the competing demands on a teacher's time and curriculum space, but an evidence-based program needs to be implemented with fidelity to achieve the intended benefits. One function of the wellbeing staff (action 3.1.c) would be to ensure selection of programs that have been accredited as evidence-based, and to oversee their implementation.

"Addressing bullying needs to start much earlier… How to create sense of good digital citizenship amongst children? How do we support parents to establish good technology habits at home?... How do we create a sense of kindness and ethical behaviour online? There's a lot that could be done around using digital technology that could go a long way to addressing some of the bullying issues we have"—Education representative

A key aspect of how educators should respond when concerned about a students' wellbeing is to discuss their impressions with the parents. Conversations between educators and families are important as both have an opportunity to observe children in a different context from the other, which provides useful insights into why a child might be struggling and how they can be best supported. Schools and early childhood education centres **need specific strategies and tools to discuss mental health concerns with parents.** These may be adapted from materials that address more generic communication, e.g. Raising Children Network's 'effective communication' series which provides guidance for professionals on communicating with parents, and guidance for teachers on encouraging parental involvement in school (action 3.2.c).[136]

"If there was more of a general dialogue, particularly in the school because they were seeing things that I wasn't, that would have helped"—Parent / carer of a child with mental illness

School engagement and mental health are also linked, with mental illness often a major reason for disengagement from education and a significant barrier to returning to school.[137] School disengagement can occur at different levels, and while it is less common in primary than in high schools, up to 18% of primary school students attend less than 90 per cent of the time.[138]

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Disengagement from education is not always as obvious as a child being physically absent from the classroom. They could be disengaged in the content of the lesson, or with the particular class or teacher, or with school as a whole. At all levels, disengagement presents a risk for the child's educational attainment. This in turn has downstream impacts on later likelihood of employment, low income, social exclusion, risky health behaviours (e.g. such as smoking and alcohol abuse) and engaging in crime, all of which contribute to greater likelihood of development of mental illness.

Young people reported that when their school engagement was disrupted by challenges they were experiencing in their home environment (for example, they were frequently late or missed school), the school would often respond with punishment instead of trying to understand what the issues were and how they could be accommodated.[30] Schools and educators need support to develop procedures for **proactive outreach** to be automatically triggered when a student's attendance declines below a pre-determined level. In addition to reviewing school disciplinary policies and practices (action 3.1.a), primary school educators would benefit from additional opportunities to consider how they respond to student disengagement and behavioural issues. In an effort to move away from punitive disciplinary responses, these instances should trigger consideration of the child's mental health and a care plan should be developed in collaboration with both the child and their family. Similarly, early childhood educators must be supported to adopt a **trauma informed approach** when children and families are disengaging from their service (action 3.2.d).

"I had to be a parent when I was at home because my Mum wasn't always so well. I'd have to look after my little brother, make sure my sister was ok… when I got to school, I was usually late, I would get picked on by the teachers… I would give the reason and they wouldn't believe me; they would think I'm lying" – Young person with experience of mental illness

In the preschool years, early childhood education can be an avenue to address social disadvantage, including as a way of helping vulnerable children reach their full potential, and to reduce intergenerational cycles of poverty and incarceration but not all children and families access it. While the Commonwealth Department of Education has a Child Care Safety Net to provide additional assistance to services looking after the most vulnerable children, only a third of the anticipated 70,000 low-income families expected to access these entitlements have actually done so.[139] The GAP Taskforce on Early Childhood Education identified that the factors affecting families' lack of participation are more complex than access to funding or facilities. Their findings indicated that integrating health, welfare, school and early learning on the same site improves outcomes, along with engaging local communities to encourage use of these services.[140]

Things we can build on

Several State and Territory Education Departments have **Student Wellbeing Plans**. Some schools are choosing to implement programs that focus on key issues such a bullying. There are strong examples of school-based child welfare programs that have been designed to be delivered in mainstream schools to cater for students needing complex educational and therapeutic support. Programs are delivered to educators via structured professional development, consultation and mentoring, and are based on the rationale that children's biological and developmental responses to trauma need to be addressed before they can engage with learning content. [141]

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The **Commonwealth Department of Education's Inclusion Support Program**[142] provides additional support for children that need it, and the guidelines have recently been expanded to include children who are not coping, are struggling, or unwell. The Inclusion Support Program's objectives are to:

- support eligible mainstream Early Childhood Education and Care (ECEC) services to improve their capacity and capability to provide quality inclusive practices for all children;
- address access and participation barriers and to support the inclusion of children with additional needs; and
- provide parents or carers of children with additional needs with access to appropriate and inclusive ECEC services so parents or carers can increase their activity including work, study and training.

Research indicates that **students from disadvantaged backgrounds** profit most from a combination of whole-of-school and targeted programs. The evidence also suggests that specific student belonging and engagement programs in schools had the greatest impact on academic achievement.[143] A pilot program, Thriving Together is currently underway in NSW. Based on a **social prescribing framework**, the program is designed to promote the benefit of early learning to families living in poverty and to break down the barriers to early learning and childhood care. It has been designed to create a wraparound inter-agency response to support the 'front line' parent(s), and to support GPs with an easier referral pathway to access external services and reduce demand on primary care.[144]

Actions 3.2	
a.	Require all early childhood learning services and primary schools to develop a comprehensive wellbeing plan, which should outline what the service or school will do to address issues identified as a priority for their students (including those identified as part of actions 3.1.a and 4.1.c). Progress against these plans should be reported on regularly.
b.	Make funds available for schools to implement quality improvement activities related to student mental health and wellbeing, including the delivery of evidence-based programs targeting the needs identified as part of action 3.2.a.
c.	Adapt existing resources and training programs to provide educators with the skills to discuss mental health concerns about a child/student with their parents or carers.
d.	Establish and implement trauma-informed procedures for responding to students disengaging from education.

Objective 3.3 Well-equipped educators

Educators are uniquely positioned to identify signs when children are struggling and to facilitate their connection with supports. However, they are not always provided with the knowledge or support to ensure they are capable and confident to do this effectively. Amongst educators, there is **variability in awareness of the signs that children are struggling** or not meeting social and emotional developmental milestones. Educators also experience difficulties identifying the threshold at which they should seek additional support for a child and are not always confident raising concerns if they were not first raised by a parent.

"[Teachers] aren't necessarily referring because they don't know the seriousness of some of the symptoms" — Education representative

Despite this, there is interest amongst educators in improving understanding of how children's mental health and wellbeing can be supported in the classroom. There is a need to **develop professional teacher training** (action 3.3.a) on key topics such as:

- Identification of early warning signs that a child is struggling with their mental health and where to refer families when necessary.
- How to have effective conversations with parents about their child's wellbeing.
- Appreciation of the broader Social and Emotional Wellbeing concept for Aboriginal and Torres Strait Islander communities.
- Trauma-informed approaches to education.

There is also a need to have **clear guidelines and processes in place, for educators to follow when they suspect a child or family are struggling**. This is likely to be involving the student wellbeing coordinator as the first step (action 3.3.b). Wellbeing coordinators also require sufficient education and training to perform their role (action 3.3.c).

Educators play an important role as informed members of management teams, including to implement support plans in the school environment. In the first instance, educators should be aware of the range of options for children and families to seek mental health and wellbeing supports (action 3.3.b). This includes supports and services provided through the school and the local community, as well as state or nation-wide services. This may be achieved through professional development training and staff meeting / induction processes.

In order for the child to receive the support they need, treatment plans depend on educators being able to **develop effective working relationships with external health providers as well as parents**. Wellbeing staff should have responsibility for establishing and maintaining strong relationships with local service providers including paediatricians, psychologists, allied health professionals, community health centres, and mental health services. This could be facilitated through a designated contact within the service who is known to (and works with) the school staff with wellbeing responsibilities (action 3.1.c, action 3.3.b).

In order for educators to be able to support students and their families, **educators' mental health and wellbeing needs to be supported**. Without this support, educators are at greater risk of feeling burnt out and experiencing their own mental health struggles. While there are programs such as Employee Assistance Programs, these are not available to all educators. Wellbeing staff should promote relevant staff training on mental health and wellbeing, including policies, procedures and information about available services for staff and students both internally and externally e.g. support via an educator's regular GP (action 3.3.d).

While educators have diverse roles and cannot be expected to have the same level of expertise in mental health as mental health professionals, **a minimum standard of professional development** in relation to child mental health should be applied (action 3.3.e). For example, educators could be required to complete accredited professional development relating to mental health or wellbeing once every two years. Professional development should be accredited according to national guidelines and paid protected time should be available for completion of professional development activities.

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Things we can build on

The **Australian Professional Standards for Teachers** set out what teachers should be aiming to achieve at every stage of their career.[145] These include creating and maintaining supportive and safe learning environments, engaging in professional learning, and engaging professionally with colleagues, parents/carers and the community.

Programs are available for primary schools to help make it easier for educators to identify children who are struggling, in order to offer them school-based interventions and/or external referrals. One model is based on training educators in the following: noticing changes in mood or behaviour (that may indicate difficulties in managing emotional distress), building trusting and supportive relationships with parents and carers, inquiring sensitively about the child's circumstances, and planning the first steps and referrals within or outside the school setting.[146]

One consequence of the move to home-based learning as a result of the recent pandemic, has been increased opportunities for communication with parents. This has **strengthened the relationship between teacher and families** and had given some parents and carers a new appreciation for the strengths and difficulties their children have in different domains. A similar advantage has been seen with the **introduction of telehealth measures,** which have increased opportunities for health professionals to connect with educators to support children in their care.

Actions 3.3	
a.	Develop professional learning courses/modules specifically designed for educators that focus on key mental health and wellbeing topics.
b.	Create clear processes to guide educators when concerned about the mental health of a student/child, including up-to-date information regarding the range of locally available or online support options for children and families (note role of Wellbeing Coordinators, see action 3.1.c).
c.	Provide designated Wellbeing Coordinator staff (see action 3.1.c) with appropriate training to undertake their role.
d.	Ensure formal, independent mental health and wellbeing supports are made available to all educators for their own mental health and wellbeing.
e.	Establish professional learning requirements for educators in relation to mental health, with paid protected time for participation.

The below table outlines some proposed **indicators of change**. If the objectives of this focus area are realised, we would expect to see improvements in the below.

Focus Area 3: Education settings – indicators of change	
3.1	Extent to which children enjoy a sense of belonging at early childhood learning services and primary schools, and prevalence of bullying and discrimination.
3.2	Level of children's engagement with their education, and strength of relationships between educators and the children's parents and carers.
3.3	Implementation progress of planned program of activities to improve student wellbeing, coordinated by designated wellbeing staff.
3.4	Strength of relationships between schools / early childhood learning services and locally available mental health service providers.

3.5	Rates of children's participation in evidence-based mental health and wellbeing programs through schools and early childhood learning services.
3.6	Educator knowledge and confidence to support the wellbeing of the children in their care.

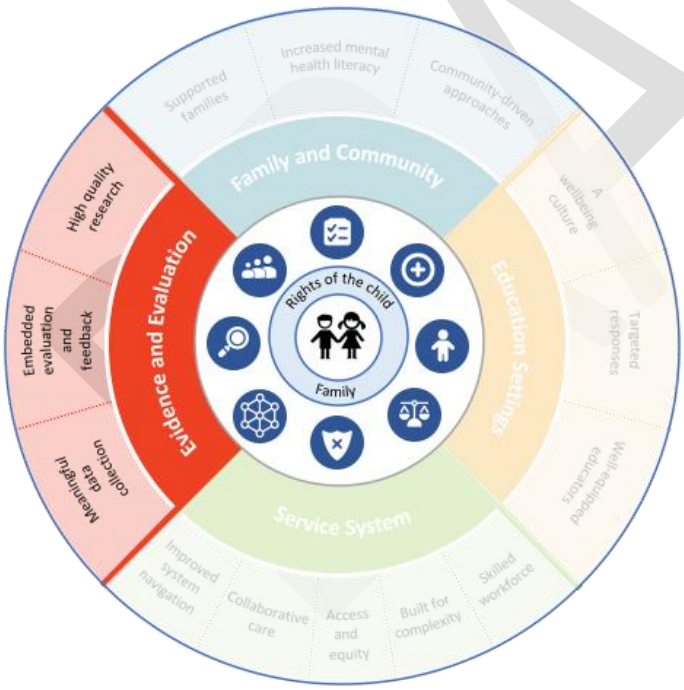
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Focus Area 4: Evidence and Evaluation

In the optimal system, programs and services provide consistently high quality supports for children and families. This focus area speaks of the importance of embedding a culture of evaluation in child and family mental health supports. This culture of evaluation includes:

1. Providing services and programs that have **proven to be effective** through robust evaluation;
2. Ensuring that services are delivered and programs are **implemented with high fidelity** (i.e. they are implemented completely and with alignment to the way they were evaluated as effective); and
3. Embedding **ongoing feedback loops** to check that programs are having the intended impacts in Australian contexts and to inform continued improvement. Importantly, these feedback loops must involve the children and families who use the services and participate in the programs.

The optimal system is comprised of evidence-based programs and services, where the impact on outcomes is monitored and evaluated, and funding is allocated accordingly. Key objectives in this focus area include improved collection and use of data, ensuring ongoing feedback and evaluation, and use of evidence to deliver quality services.



Evidence and evaluation objectives:

4.1. Meaningful data collection

4.2. Embedded evaluation and feedback

4.3. High quality research

Objective 4.1 Meaningful data collection

Population data about children's mental health and wellbeing are important for informing decision making in relation to policy and funding, as well as for measuring changes over time. We need reliable data to make sure that the resources are going where they are needed, and when changes are made, that they are having beneficial impacts for children and families. Meaningful data are also essential to monitoring whether systems and processes are changing in the right way, and whether

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the anticipated improvements are actually being achieved. **Children's mental health is an area where key population data are missing.**[3] There is currently no regular national data collection or reporting regarding children's overall mental health and wellbeing. To inform relevant policies and services, it would be helpful to have data relating to infancy (0-2 years old), preschool (3-5 years old) and primary school (6-12 years old).

There has been increasing interest in **perinatal mental health screening** as a result of increased understanding about the prevalence of perinatal anxiety, stress and depression, particularly in mothers.[147] While there is currently a Perinatal National Minimum Data Set, this does not include any data elements related to mental health (action 4.1.a).[148] Additionally, **Australia does not have a national approach to monitoring screening rates**[149] despite Australian clinical guidelines recommending universal antenatal screening of pregnant women.[150] Such monitoring would help inform strategies to increase perinatal screening (action 1.1.a). Where screening rates have been measured (based on use of the Edinburgh Postnatal Depression scale), screening rates are much higher in public than private settings, with a 71.3% overall screening rate in the six month period of data collection.[151] In general, women were less likely to be screened if they were older (aged 36+), were wealthier, were single or separated or if they identified as Aboriginal or Torres Strait Islander.

During the **preschool years**, children typically have regular contact with health services such as GPs and child and maternal health nurses. During these contacts, services are able to check on a child's progress against developmental milestones and facilitate routine vaccinations. These contacts may also provide opportunities to **systematically gather information on the mental health and wellbeing of children** (action 4.1.b). For the individual child, this would be beneficial in terms of connecting them to supports if needed. For the community more broadly, the information gathered during these contacts could better inform national approaches to policy and funding.

For **school age children**, primary schools provide a unique opportunity to gain insights into the mental health and wellbeing of our children. There is a well-known association between student wellbeing and educational outcomes, such as attendance, connectedness and engagement with school, and NAPLAN performance.[152] However, there is a key gap in national data collection in relation to **measures of student wellbeing** in education settings. This information is important to both enable improved understanding of the development of students' social and emotional skills[153] and to inform how schools can best support their students' wellbeing (action 4.1.c).

Difficulties accessing data across sectors such as education, justice and community health have been identified as a barrier to research in child mental health. In work undertaken by the NMHC to develop a National Mental Health Research Strategy, this was identified as the top priority to better progress research in this domain. A collaborative and coordinated approach to data collection and sharing is required across the various sectors that play a role in children's mental health. These barriers should be addressed to facilitate better quality research (action 4.1.d).

The **service features that are important, even essential, to service users can differ between cultures and communities**. This means that services designed in the context of one culture or community may not translate effectively into another.

"What is the feedback and how are services flexible and responsive to adapt to what a particular community or subgroups within a community need in terms of mental health… it changes overtime as communities develop or new communities come"—Professional working in migrant and refugee services

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This is evident when services designed from the perspective of non-Indigenous Australians are delivered to Aboriginal and Torres Strait Islander Australians. **Aboriginal and Torres Strait Islander services report that often these services are rejected by communities as they fail to recognise the importance of factors such as culture, history, and community connection**. For services used by Aboriginal and Torres Strait Islander children and families, the evaluation component needs to value Aboriginal approaches to evidence and expertise, and to be informed by Aboriginal and Torres Strait Islander ways of knowing, understanding and evaluating (actions 4.1.e and 4.1.f). However, this represents a challenge to obtaining service funding, since there is often not a formal evidence base (e.g. randomised controlled trials), despite services observing the benefits of their approaches within their communities

"Shift resources to the prevention side of things, to being co-designed and led by Aboriginal Community Controlled Organisations… you'll definitely get much more traction in terms of service outcomes… In terms of commissioning services… we end up with a concept of co-design that is not real because the commissioning of service parameters has already been set"—Aboriginal and Torres Strait Islander health professional

For Aboriginal and Torres Strait Islander communities, **a lack of data sovereignty means that programs or policies fail to reflect Aboriginal and Torres Strait Islander priorities, values, cultures, worldviews and diversity**.[154] When data is limited or does not reflect the experiences of those who are the subject of the data, then interventions (services, programmes etc.) that are designed on the basis of this evidence are unlikely to be fruitful.[155] This Strategy supports data capture and evaluation that is the result of a co-design process informed by Aboriginal & Torres Strait Islander perspectives and expertise (action 4.1.e) and development of measures that appropriately represent cultural conceptualisations of wellbeing in collaboration with the relevant communities (action 4.1.f). This includes better integration into data analysis of culture, cultural practices and experiences. In order to inform improvements, gap analysis, and track progress and outcomes for Aboriginal and Torres Strait Islander children and families.

Service needs for culturally and linguistically diverse, refugee and asylum seeker communities also differ. Many of these communities will have differing ideas and conceptions around mental health, family and the role of community. These, as well as the unique experiences and challenges of communities have direct impacts on what children and families need from services. Services should ensure that feedback is obtained on an ongoing basis from children and families who use them, to build the evidence base for effective service delivery and to **facilitate the tailoring of services to the unique needs of communities** (action 4.1.f).

"Contextualising the situation… talking about the journey and migration and refugee experiences… we find that engages communities, individuals and families into services"—Professional working in migrant and refugee services

Things we can build on

Longitudinal data are particularly useful for exploring developmental pathways and identifying risk and protective factors, as evidenced by the insights gained from the **Longitudinal Study of Australian Children**. This study explores a range of development and wellbeing questions and has provided insights in areas such as the impact of bullying on mental health, parent relationships with children and sleep.[156] Commencing in 2003-04, data has been collected from two cohorts each year with study participants now in their teens and young adulthood.

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Other Australian longitudinal studies of note include **the Raine Study** and **the Mater-University of Queensland Study of Pregnancy (MUSP**). The Raine Study was established in 1989 as one of the largest prospective cohorts of pregnancy, childhood, adolescence and adulthood in the world. Outcomes from this research have delivered findings on the link between sleep patterns in childhood and adult mental health, and maternal smoking on children's physical and mental health.[157] The MUSP began in 1981 as a prospective study of 8,556 pregnant women, initiated after their first clinic visit. Data collection has occurred across various time points for both mothers and children, with a new phase examining outcomes in the third generation (grandchildren of original participants) about to commence.[158]

The **Australian Early Development Census** (AEDC) is a current nationwide data collection of early childhood development held every 3 years.[159] Data are collected from teachers at the time children commence their first year of full-time school. The AEDC has five domains: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills (school-based); and communication skills and general knowledge.

The Australian Institute of Health and Welfare has recently included three **perinatal mental health screening data items in their National Best Endeavours Data Set** to be collected from 1 July 2020.[160] This is the first step in getting the items into the Perinatal Minimum Dataset and jurisdictions are already working towards this goal.

As part of the **Be You evaluation,** the Commonwealth Department of Health is funding the University of Queensland to develop a costed plan for future longitudinal research study on national promotion, prevention, early intervention and prevention mental health programs.

Actions 4.1	
a.	Expand the Perinatal National Minimum Data Set to include indicators of mental health screening in the weeks before and immediately after birth (see also action 1.1.a).
b.	Establish national system for pooling key information related to child mental health (i.e. indicators) gathered via routine developmental checks or vaccinations conducted during the preschool years.
c.	Establish a national minimum dataset on student wellbeing with annual collection conducted via schools and regular reporting on how schools are addressing any issues identified.
d.	Task the Inter-Departmental Committees proposed by this Strategy (see section 4.1) with resolving current barriers to relevant data sharing across sectors such as education, justice and community health, for the purposes of informing child mental health and wellbeing.
e.	Ensure that data capture and evaluation practices related to Aboriginal or Torres Strait Islander child mental health and wellbeing are consistent with the principles of co-design (i.e. with significant involvement from the communities represented in the data).
f.	Develop measures that appropriately represent cultural conceptualisations of wellbeing in collaboration with the relevant communities, where such measures do not currently exist.

Objective 4.2 Embedded evaluation and feedback

There is a large and growing number of clinical services and programs targeted at children's and families' emotional wellbeing. However, only a small number of these have **robust evaluation embedded into program design.** This makes it difficult to reliably determine the impact of one program over another. Furthermore, funding contracts rarely cater for or require, sophisticated evaluation of program outcomes and impact. While some services are collecting data to enable program monitoring and reporting, many providers do not have capacity to collate data nor to conduct robust program evaluation. Service providers should be required to build evaluation into their programs and funders to make this a requirement of ongoing funding (action 4.2.a). Plans for service evaluation should be made at the time services are commissioned, with funded (protected) time for service staff to dedicate to evaluation activities and training.

This expectation of embedded evaluation should also apply to the **programs and wellbeing resources within schools**. (action 4.2.b). While there are a large number of wellbeing programs and resources available to schools, the majority of funding for programs is spent on their delivery with minimal support for program evaluation.[152] The lack of evaluation data relates to both outcomes and the implementation of wellbeing initiatives, as most programs providers do not collect evidence to support iterative program improvement and increased effectiveness.[152] Furthermore, schools often struggle to implement programs consistently and with fidelity (objective 3.2). This problem is underpinned by a lack of implementation evaluation to understand how programs are being delivered on the ground and to identify barriers to effective delivery.[152] This lack of evidence should be addressed (action 4.2.c). **Evidence about the strategies and actions** that are making a positive difference to the wellbeing of children should also be collected and communicated nationally (action 4.2.d). Potentially including specific funding to trial and evaluate innovative school-based approaches, and promotion of existing datasets that could inform policy and research.

Those using services have a valuable and essential perspective for informing service delivery. The ability of children and young people to contribute their feedback and ideas can often be mistakenly underestimated. It's important to implement evidence-based programs, but perhaps even more important to hear whether the intended audience finds them useful. Children and families using services, or who have used services in the past, are often keen to provide feedback, and their input on what worked well or didn't work well for them is crucial. In fact, program or service evaluations are most useful when they focus on the key outcomes that are important and meaningful to the children and families themselves (action 4.2.e).

Things we can build on

Progress has been made in the development and use of **routine outcome measures** to help measure the quality and effectiveness of mental health services in Australia.[161] Routine outcome measurement involves the systematic collection of clinician and patient feedback each time services are provided.[161] This data is used to inform clinical practice, service planning and policy development.[162]

In recent years there has been an increased focus on **patient reported outcome and experience measures**, emphasising the importance of the perspective of consumers and measuring the outcomes which are important to them. Patient reported outcome measures capture consumers' perceptions of their health,[163] while patient experience measures capture consumers' views and perspectives about the services they received (e.g. wait times, physical environment and interactions with clinicians). **Your Experience of Services survey** is an example of a survey that has been used in

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some Australian States to measure items such as how safe, welcome and respected individuals and families felt accessing mental health services.[164] There is a 'Family of Youth' component to the survey which targets parents, families and carers of children and young people accessing services.[165]

While **co-design with children and young people** has additional challenges, it has been successfully deployed to develop e-health interventions for treatment of conditions including anxiety, and for self-monitoring during treatment for depression.[166] In some child mental health related fields, such as allied health, there is a move away from the traditional model of practitioners as 'consumers' of research, toward greater involvement in research training and leadership, knowledge translation, and evidence implementation.[167]

An evaluation process is currently in place for the national Be You curriculum. By **embedding evaluation as part of the implementation process**, the Be You team will better understand the outcomes that are emerging, and understand whether the initiative and processes are being implemented with fidelity. The results of the evaluation are due in May 2021. An evidence-based rating scale for on-line mental health programs for schools has also been developed, to be hosted under the Be You programs directory from October 2020.

Actions 4.2	
a.	Require and resource service providers to build evaluation into their programs from the beginning, with reporting on finding a requirement for further funding.
b.	Require wellbeing programs delivered within schools or early childhood learning settings to have demonstrated evidence of improving student/child wellbeing.
c.	Include implementation evaluation as part of the broader evaluation of child mental health and wellbeing programs to highlight what is required to deliver these programs with fidelity.
d.	Openly communicate the evaluation results for child mental health and wellbeing programs that are being delivered, including both positive and negative outcomes.
e.	Require service and program providers to enable children and their families to provide feedback on the services they are receiving. Require service providers to outline how they use this feedback to inform quality improvement of their services.

Objective 4.3 High quality research

The development of new approaches to meeting the mental health needs of young people have led to national reforms and the development of a framework for youth mental health research in Australia.[168,169,170] However, **coordinated multidisciplinary efforts involving community consultation have yet to be similarly applied to children under 12 years of age** and there is an overall lack of trials in child mental health. Yet, the 0-12 years age range offers a unique window for research exploring mechanisms that may cause and maintain mental illness. This includes causal processes for specific diagnoses, and those processes that span across multiple disorders.[171] In addition, trans diagnostic approaches offer an opportunity to guide clinicians when children appear with complex presentations.

Moreover, apart from general factors like severity and parental mental health, **knowledge is lacking around risk factors** for persistence of symptoms from childhood into adulthood. Consequently, there is a lack of treatment programs specifically targeting children at high risk, who will likely need

a more intense treatment program. There are also no large scale harmonised data collections in child development, or in child and adolescent mental health programs (apart from the routine outcome measures) to improve the identification of children at high risk.

There are **evidence-based interventions available for some childhood onset disorders**, for example Cognitive Behavioural Therapy for anxiety disorders and pharmacological treatment for ADHD[172,173] but there are **also huge gaps in our knowledge**. To illustrate, psychotherapy for depression seems less effective in children under 13 years,[174] the choice of pharmacotherapy for children with ADHD is now a case of trial and error,[172] and there are not many evidence based interventions for ASD after the early years (action 4.3.a). What works for individual children can also vary, and not every child will find the standard treatment modality acceptable or useful.

"There was a dismissiveness and if I didn't talk, [the counsellor] wouldn't try very hard to get me to talk or help me find a way to talk about my experiences, even if it was through writing or pictures. No one tried that until I was well into grade 7"—Young person with experience of mental illness

Ongoing **clinical trials can play an important role in improving best practice in treatment guidance and guidelines**. It is argued that compared to other areas of medicine (e.g. oncology), the resources and culture in relation to children who are ill taking part in trials are lacking in mental health.[175] Research is also beneficial for those who participate, beyond just global knowledge generation. It is known for example, that participants in clinical trials tend to have better outcomes than those with similar characteristics who just receive standard care. Yet, despite the paucity of knowledge about the best treatments for many of the most common mental illnesses, there is not a strong culture of research as part of standard clinical practice in child psychology, allied health and psychiatry.[175] We should ensure that research into the mental health needs and treatment outcomes for children receives adequate priority for funding (action 4.3.b).

Current ethics processes often making research with children challenging and this should be addressed (action 4.3.c). There is a focus by Research Ethics Committees on children's status as 'vulnerable', with frequently raised concerns about issues of consent, methods of recruitment, care and protection of participants, scientific design and confidentiality.[176,177] While it is reasonable for ethics committees to be concerned about these issues, including children and families (or consumers generally) in the design and development of research questions and research methods would be a helpful strategy to help navigate these concerns (action 4.3.d). Doing so would also increase the likelihood that the subsequent research will address real world treatment issues and questions.[178]

In the optimal system, children would receive **measurement-based care where treatment is optimised based on ongoing feedback**.[179] Clinical measures of outcomes of treatment would be augmented by the collection of information on other factors, including family characteristics, school functioning, and biomarkers, to support analysis to identify which children do not fully recover and why. These results could also be used to set up treatment trials to target those children who are still struggling in order to improve outcomes.

Things we can build on

The **Million Minds Mission** (under the Medical Research Future Fund) has prioritised participatory mental health research into prevention and wellness, early intervention and treatment strategies for children, youth and emerging adults. To date, two major grants have been awarded for projects

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focussed on child mental health, including Emergency Department management of acute mental health crises and translating evidence-based interventions into population-level digital models. With another three grants awarded for projects focussed on mental health in Aboriginal and Torres Strait Islander communities including, generation of Indigenous patient-centred, clinically and culturally capable models of mental health care, culturally appropriate models for improving mental health and wellbeing in Aboriginal and Torres Strait Islander young people.[180]

The **Ethics Research Involving Children (ERIC)** project aims to encourage ongoing international collaboration around improving ethical research involving children. It developed in response to an identified need for ethical guidance to support researchers throughout their research processes, and to create common resources for research funders and ethics review committees. The ERIC resources are freely available online, including a monitored forum to promote questions, discussion and debate, along with a resource library and case studies from researchers examining actual ethical challenges across different contexts and research methodologies, and the response to them at the time they arose.[181]

James Lind Alliance Priority Setting Partnerships (PSP) aim to identify and raise awareness of research questions directly relevant to consumers, carer and health practitioners. The partnership model uses a participatory process involving health and social care professionals, carers and families and those with lived experience of the health area in question. In 2018, they conducted a PSP focussed on mental health in children and young people that helped to identify the top 10 unanswered research questions.[182]

Actions 4.3	
a.	Advocate for research into child mental health needs and treatment as a priority, arguing for child mental health research to receive funding that is comparable to child physical health.
b.	Identify research priorities for child mental health, incorporating a focus on children and families who are most vulnerable to mental illness and the current gaps in our collective knowledge regarding treatments. Allocation of funding must be aligned with these identified priorities.
c.	Review current research ethics approval processes, looking for ways to facilitate innovative research without compromising the safety of research participants.
d.	Require researchers to consult with children, family and relevant community members as part of the research design process, with the expectation that those involved are also informed of any results of the research.

The below table outlines some proposed **indicators of change**. If the objectives of this focus area are realised, we would expect to see improvements in the below.

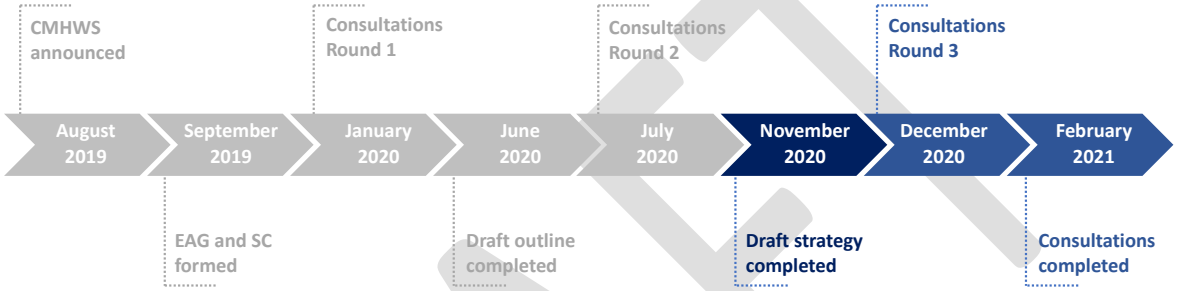
Focus Area 4: Evidence and Evaluation – indicators of change	
4.1	Extent to which Australian research grants and publications focus on the key priority areas related to mental health and wellbeing of children aged 0-12 years and their families.
4.2	Development and use of new national datasets on child mental health and wellbeing, as well as rates of data sharing across sectors.
4.3	Degree of implementation of evidence-based child mental health and wellbeing programs, including embedded evaluation and public reporting of results.

4.4	Number of service and program providers reporting on child and family experiences, with clear plans for how feedback is used to inform quality improvement.
4.5	Extent to which researchers consult with children, families and communities as part of the research design process, and extent to which research is conducted as part of routine clinical practice.

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4. Next Steps

This draft Strategy will go through a third round of consultations before being finalised early in 2021 (see below). The nature of children's mental health and wellbeing requires this Strategy to reach beyond the scope of mental health services, to include families, education settings, and communities. We acknowledge that the recommended actions outlined in this Strategy require the support of multiple government portfolios at both the Commonwealth and the State and Territory levels. The NMHC will arrange specific consultations with the relevant portfolios (e.g. health, education) and key stakeholders (e.g. Aboriginal and Torres Strait Islander representative groups). In particular, we are keen to hear from each of the jurisdictions on whether the recommended actions outlined in this Strategy will meet the needs of children and families across Australia.



4.1 Implementation

For this Strategy to have the intended impact on children's mental health and wellbeing, it must be acted on. To this end, we recommend the NMHC establish a **National Steering Committee**, with representation from across relevant Commonwealth Government portfolios (e.g. health, education, social services), Aboriginal & Torres Strait Islander representatives, implementation experts, and people with expertise in the provision of child mental health supports and treatment. This Steering Committee would be time limited and support the NMHC to develop an implementation plan and initiate the process of monitoring progress against the relevant indicators of change. Input should be sought from parents, carers, children and young people as required.

To assist with implementation planning, we recommend an **Inter-Departmental Committees** (IDC) be established at the Commonwealth level as well as within each jurisdiction, to identify what each government department could do towards achieving each of the objectives in the Strategy. The IDCs would have a critical role in ensuring the proposed actions were supported by all relevant departments and ensure a genuinely collaborative approach to overcoming any barriers. Therefore, the IDCs must include representatives from disability, justice, education, family support, early childhood, and health (maternity, primary care, maternal and child health, mental health). They must also include representation from Aboriginal and Torres Strait Islander communities, parents, carers, children and young people.

Each IDC should regularly (e.g. every 3 years) report to the Commonwealth, State and Territory Health Ministers on their progress against each of the objectives, with an independent organisation monitoring the proposed indicators of change nationally. The final indicators used and the frequency of reporting will be determined through agreement between the data custodians and IDCs.

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5. Summary of Actions

The order in which the Focus Areas and associated actions are presented in this Strategy is not indicative of their priority for attention or implementation. Many of the proposed actions would need to be implemented concurrently as they are dependent on each other. Responsibility for implementation of these actions may be shared between groups or amended as requirements are scoped. However, an overview of who is likely to be responsible for each action is included below.

Focus Area 1: Family and community	
Objective 1.1: Supported families	Who's responsible?
a. Implement perinatal mental health screening for expectant parents in maternity services (public and private), monitoring and reporting on alignment with the National Perinatal Mental Health Guidelines (see action 4.1.a).	State and Territory Governments
b. Ensure evidence-based resources that provide practical suggestions on how families can support children's emotional wellbeing are made easily accessible and promoted widely. These must include specific resources for families where there are additional physical, neurodevelopmental or cultural needs, developed via genuine co-design.	PHN/LHD
c. Routinely offer evidence-based parenting programs to parents and carers at key developmental milestones for their child – for example, the perinatal period (from 6 weeks), at commencement of early childhood education (age 2-4); transition to primary school (age 4-6), when their child moves to the penultimate year of primary school (age 10-11); and at the commencement of high school (age 12+).	Commonwealth, State and Territory Governments
d. Implement a nation-wide campaign aimed at promoting the availability and value of parenting programs, with specific efforts to address stigmatising attitudes towards participation in such programs.	Commonwealth Government
e. Promote parent helplines and hotlines (available in each state and territory) as the first 'port of call' for any parenting concerns.	State and Territory Governments
f. Include emotional wellbeing modules and information about locally available supports in all antenatal and parenting training courses delivered to new parents.	State and Territory Governments
g. Design systematic methods for identifying children who do not start primary school by the required age, with this prompting a compassionate outreach of support to engage the child and family.	State and Territory Governments
Objective 1.2: Increased mental health literacy	Who's responsible?
a. Plan and implement a program of activities (e.g. campaigns) to increase parents' and carers' understanding of the signs that a child needs mental health support. These activities should directly address any common myths or misconceptions about child mental health and wellbeing.	Commonwealth, State and Territory Governments

b. Ensure mental health literacy resources do not assume any background knowledge about mental health, use terminology and examples that have universal relevance wherever possible, and are translated into languages other the English.	Commonwealth, State and Territory Governments, and Parenting Services
c. Provide resources about mental health to those in community organisations working or volunteering with children, including information about where they can direct children and families if they need additional mental health and wellbeing support.	State and Territory Governments, and Local Councils
Objective 1.3: Community-driven approaches	Who's responsible?
a. Identify and invest in communities that could benefit most from community level support; for example, those with low school attainment, high unemployment, poor physical and mental health, high imprisonment rates, high incidence of child abuse or neglect, or any other factors that contribute to or maintain an environment of social and economic disadvantage.	Commonwealth, State and Territory Governments, and Local Councils
b. Work with communities to develop and deliver tailored programs focused on improving child wellbeing and based on the key characteristics of successful place-based approaches. These may build upon existing social networks organically built through contact with maternal and child health, educational settings, sport and other community settings.	Commonwealth, State and Territory Governments, and Local Councils
Focus Area 2: Service system	
Objective 2.1: Improve system navigation	Who's responsible?
a. Build on and promote existing online navigational tools (e.g. HealthPathways) to enable both providers and community members to find the most appropriate locally available supports for children struggling with their mental health.	Commonwealth, State and Territory Governments
b. Review people's experience of transitions between services (including across jurisdictions and sectors) and redesign processes to ensure children and families experience optimal transition of care.	State and Territory Governments
c. Establish model of integrated child and family care (see Box 3) networked across Australia that provide holistic assessment and treatment for children 0-12 years old and their families.	Commonwealth, State and Territory Governments
Objective 2.2: Collaborative care	Who's responsible?
a. Incentivise all relevant service providers to participate in case conferencing. This could be done by enabling providers of all disciplines to claim the existing case conferencing Medicare item numbers.	Commonwealth Government
b. Enable service providers to claim Medicare payments for consultations with parents and carers as part of a child's mental health treatment, removing the requirement for the child to be present.	Commonwealth Government
c. Require mental health professionals to communicate with educators and other service providers about a child's treatment and support plan, with the family's permission and subject to this being deemed clinically appropriate.	Commonwealth, State and Territory Governments
d. Equip child mental health services to identify parents and carers who are struggling with their own mental health and require them to connect those parents and carers with appropriate supports.	Service provider organisations

e. Equip adult mental health services to identify any children in their clients' care who need mental health support and require them to connect those children with appropriate supports.	Service provider organisations
f. Ensure free or low cost mental health services are accessible to parents and carers with mental illness.	Commonwealth, State and Territory Governments
g. Include content specifically targeting parents in workplace mental health programs, with a particular focus on new parents during the return to work phase.	Workplace mental health program providers
Objective 2.3: Access and Equity	Who's responsible?
a. Increase resourcing for public mental health services to support children age 12 and under. Funding should be attached to implementation of the integrated model of child and family care (action 2.1.c)	Commonwealth, State and Territory Governments
b. Provide accessible and affordable training and resources to GPs, paediatricians and other care providers to help them respond to children and families who are struggling.	PHN
c. Implement innovative service delivery models that integrate face-to-face and telehealth consultations, digital interventions, and phone helplines to improve access to services.	PHN/LHD
d. Commit to ongoing Medicare funding for telehealth services.	Commonwealth Government
e. Embed the principles of genuine co-design into the design, delivery and evaluation of all services supporting children and families; actively inviting involvement from the people the service aims to support.	PHN/LHD
f. Establish accountability mechanisms that encourage services to improve their accessibility for children and families, including those from Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.	PHN/LHD
g. For programs involving specialists providing advice, education or professional support to rural providers, adopt governance arrangements that make funding dependent on the rural provider's needs being met.	Commonwealth, State and Territory Governments
Objective 2.4: Built for complexity	Who's responsible?
a. Provide specific funding for care coordination to be available to children and families with complex needs.	Commonwealth, State and Territory Governments
b. Require relevant services to give priority access to children who are in State care.	Commonwealth, State and Territory Governments
c. Require all government departments to outline and regularly report on what they do to support children in State care.	Commonwealth, State and Territory Governments
d. Require relevant services to outline and regularly report on what they do to ensure they are accessible and effective for children with physical and intellectual disability.	Commonwealth, State and Territory Governments
e. Child and family mental health and wellbeing supports for Aboriginal and Torres Strait Islander communities should be delivered by Aboriginal Community Controlled Organisations wherever possible, with activity and outcome measures to be collaboratively determined between the funder, service provider and the community to ensure they are appropriate.	PHN/LHD

f. Build on holistic support models for children who have had contact with the justice system or are at risk of coming in contact with the justice system.	Commonwealth, State and Territory Governments
Objective 2.5: Skilled workforce	Who's responsible?
a. Increase requirements for early career training in child and family mental health for all relevant service providers.	Universities, specialist colleges, LHD
b. Incentivise existing service providers (including GPs, maternal child and family health nurses and allied health) to complete training in children and family mental health assessment and treatment.	Commonwealth, State and Territory Governments
c. Require public mental health services to act as training facilities for new graduates through designated training places and funding of supervision time.	State and Territory Governments
d. Create and incentivise training opportunities for mental health professionals (e.g. psychologists and psychiatrists) to work in regional and remote areas.	LHD/Specialist colleges
e. Develop cultural understanding amongst health professionals to work safely and effectively with Aboriginal and Torres Strait Islanders children and families.	Universities/LHD/Specialist Colleges
f. Build on existing models of supervision and case consultation for private practitioners using a peer support/supervision model.	Profession Peak Bodies
g. Develop workforce projections in the public sector based on evidence and epidemiology and use these to inform further recommendations.	Commonwealth, State and Territory Governments
Focus Area 3: Education settings	
Objective 3.1: A wellbeing culture	Who's responsible?
a. Conduct thorough reviews of school and early childhood policies and processes, looking for opportunities to reduce possible stigma and discrimination.	Schools and Early childhood learning services
b. Identify senior staff within early childhood learning services to be responsible for planning and coordinating wellbeing activities for their children/students.	Early childhood learning services
c. Employ wellbeing coordinators in each primary school to be responsible for (1) planning and coordinating wellbeing activities for the students, and (2) maintaining knowledge of and relationships with locally available and online supports. These positions should be funded on an ongoing basis.	State and Territory Governments, and Schools
d. Identify opportunities to incorporate conversations about mental health and wellbeing into the school or early childhood daily routines, with the expectation that all staff and students have the opportunity to contribute to these discussions.	Schools and Early childhood learning services
e. Promote evidence-based, locally available or online supports and services to children and families through schools and early childhood learning services.	Commonwealth, State and Territory Governments
f. Outline and regularly report on how schools and early childhood learning services are improving on current levels of cultural accessibility for children who identify as Aboriginal or Torres Strait Islander or from culturally and linguistically diverse backgrounds.	State and Territory Governments

g. Implement evidence-based wellbeing programs within schools and early childhood learning services, with support from existing initiatives such as Be You.	Commonwealth Government and Early childhood learning services
h. Increase accessible activities after school and during school holidays to provide respite for parents and children.	State and Territory Governments
Objective 3.2: Targeted responses	Who's responsible?
a. Require all early childhood learning services and primary schools to develop a comprehensive wellbeing plan, which should outline what the service or school will do to address issues identified as a priority for their students (including those identified as part of actions 3.1.a and 4.1.c). Progress against these plans should be reported on regularly.	State and Territory Governments
b. Make funds available for schools to implement quality improvement activities related to student mental health and wellbeing, including the delivery of evidence-based programs targeting the needs identified as part of action 3.2.a.	Commonwealth, State and Territory Governments
c. Adapt existing resources and training programs to provide educators with the skills to discuss mental health concerns about a child/student with their parents or carers.	State and Territory Governments, and training providers
d. Establish and implement trauma-informed procedures for responding to students disengaging from education.	State and Territory Governments
Objective 3.3: Well-equipped educators	Who's responsible?
a. Develop professional learning courses/modules specifically designed for educators that focus on key mental health and wellbeing topics.	State and Territory Governments, and training providers
b. Create clear processes to guide educators when concerned about the mental health of a student/child, including up-to-date information regarding the range of locally available or online support options for children and families (note role of Wellbeing Coordinators, see action 3.1.c).	State and Territory Governments
c. Provide designated Wellbeing Coordinator staff (see action 3.1.c) with appropriate training to undertake their role.	State and Territory Governments
d. Ensure formal, independent mental health and wellbeing supports are made available to all educators for their own mental health and wellbeing.	State and Territory Governments
e. Establish professional learning requirements for educators in relation to mental health, with paid protected time for participation.	State and Territory Governments
Focus Area 4: Evidence and Evaluation	
Objective 4.1: Meaningful data collection	Who's responsible?
a. Expand the Perinatal National Minimum Data Set to include indicators of mental health screening in the weeks before and immediately after birth (see action 1.1.a).	Commonwealth, State and Territory Governments
b. Establish national system for pooling key information related to child mental health (i.e. indicators) gathered via routine developmental checks or vaccinations conducted during the preschool years.	Commonwealth, State and Territory Governments

c. Establish a national minimum dataset on student wellbeing with annual collection conducted via schools and regular reporting on how schools are addressing any issues identified.	Commonwealth, State and Territory Governments
d. Task the Inter-Departmental Committees proposed by this Strategy (see section 4.1) with resolving current barriers to relevant data sharing across sectors such as education, justice and community health, for the purposes of informing child mental health and wellbeing.	Commonwealth, State and Territory Governments
e. Ensure that data capture and evaluation practices related to Aboriginal or Torres Strait Islander child mental health and wellbeing are consistent with the principles of co-design (i.e. with significant involvement from the communities represented in the data).	Commonwealth, State and Territory Governments
f. Develop measures that appropriately represent cultural conceptualisations of wellbeing in collaboration with the relevant communities, where such measures do not currently exist.	Commonwealth, State and Territory Governments
Objective 4.2: Embedded evaluation and feedback	Who's responsible?
a. Require and resource service providers to build evaluation into their programs from the beginning, with reporting on finding a requirement for further funding.	Commonwealth, State and Territory Governments
b. Require wellbeing programs delivered within schools or early childhood learning settings to have demonstrated evidence of improving student/child wellbeing.	State and Territory Governments
c. Include implementation evaluation as part of the broader evaluation of child mental health and wellbeing programs to highlight what is required to deliver these programs with fidelity.	Commonwealth, State and Territory Governments
d. Openly communicate the evaluation results for child mental health and wellbeing programs that are being delivered, including both positive and negative outcomes.	Commonwealth, State and Territory Governments
e. Require service and program providers to enable children and their families to provide feedback on the services they are receiving. Require service providers to outline how they use this feedback to inform quality improvement of their services.	Commonwealth, State and Territory Governments
Objective 4.3: High quality research	Who's responsible?
a. Advocate for research into child mental health needs and treatment as a priority, arguing for child mental health research to receive funding that is comparable to child physical health.	NMHRC
b. Identify research priorities for child mental health, incorporating a focus on children and families who are most vulnerable to mental illness and the current gaps in our collective knowledge regarding treatments. Allocation of funding must be aligned with these identified priorities.	NMHRC, MRFF
c. Review current research ethics approval processes, looking for ways to facilitate innovative research without compromising the safety of research participants.	Research Ethics Committees and Researchers
d. Require researchers to consult with children, family and relevant community members as part of the research design process, with the expectation that those involved are also informed of any results of the research.	Research Ethics Committees

Appendix A. Membership of Expert Advisory Group and Steering Committee

CMHWS Expert Advisory Group		
Name	***Position***	***Organisation***
Christel Middeldorp (Co-Chair)	Conjoint Professor of Child and Youth Psychiatry	Child Health Research Centre, University of Queensland, and the Children's Health Queensland Hospital and Health Service
Frank Oberklaid (Co-Chair)	Director	Centre for Community Child Health, Royal Children's Hospital, Melbourne
Christine Morgan	CEO	National Mental Health Commission
Helen Milroy	Commissioner	National Mental Health Commission
Nicole Rogerson	Parent representative	CEO and Director, Autism Awareness Australia
Jim Watterston	Dean	Melbourne Graduate School of Education
Vanessa Cobham	Associate Professor	School of Psychology, University of Queensland
Warren Cann	CEO	Parenting Research Centre
Louise Wightman	President	Maternal, Child and Family Health Nurses Australia
James Best	General Practitioner	

CMHWS Steering Committee members		
Name	*Position*	*Organisation*
Ngiare Brown	Commissioner	National Mental Health Commission
Mathew Coleman	Psychiatrist, Rural Clinical School of Western Australia/Commissioner	University of Western Australia/National Mental Health Commission
Samantha Page	CEO	Early Childhood Australia
Anne Hollonds	Director	Australian Institute of Family Studies
Mohammed Usman	Clinical Director, Child and Adolescent Mental Health Services	South Australia Health
Louise Salmon	Parent representative	
Malcolm Elliott	President	Australian Primary Principals Association
Erica Frydenberg	Educational, Clinical and Organisational Psychologist	University of Melbourne
Jon Ord	A/g Executive Branch Manager, Mental Health Policy	ACT Health Directorate
Jennifer McGrath	Acting Mental Health Commissioner	Western Australia Mental Health Commission
Sandra Eyre	Senior Director, Mental Health Alcohol and Other Drugs Branch	Queensland Health
Matthew Hercus	Director, Mental Health	Victoria Department of Health and Human Services
Jeremy Harbottle	General Manager, Mental Health Alcohol and Drug Directorate	Tasmania Department of Health and Human Services
Julie Dixon	Acting Director, Mental Health – Children and Young People	NSW Ministry of Health
Colleen Gwynne	Child Commissioner	Office of the Children's Commissioner Northern Territory

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Chris Bedford	Assistant Secretary, Mental Health Services and Evidence Branch	Australian Government Department of Health
Lisa Foreman Tim Crozier	Group Manager, Families Branch Manager, Children's Policy	Australian Government Department of Social Services
Jessica Mohr/ Genevieve Watson	Assistant Secretary, Wellbeing & Engagement Branch	Australian Government Department of Education
Megan Mitchell	Former National Children's Commissioner	Australian Human Rights Commission

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