Mental Health Australia

Submission: To the Draft National Children's Mental Health and Wellbeing Strategy

12 February 2021

Mentally healthy people,
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Introduction

The Productivity Commission Inquiry into Mental Health Final Report (PC Report) states "there is a clear case for investment in child mental health and wellbeing. Such investment would not only improve the wellbeing of children and their families, both immediately and in the future; it would also save significant future government expenditure by lowering the risk of children disengaging from their education and could reduce the need for more intensive medical care and other supports."[1]

In order to build resilience in children to meet the significant challenges outlined in the PC Report, Australia needs a comprehensive system of child and family supports, spanning the continuum from prevention and early intervention through to crisis responses and therapeutic interventions for those with established serious conditions. This system should address barriers to and build on protective factors for children's mental health across the social determinants. This is the system a National Children's Mental Health and Wellbeing Strategy should outline.

With this in mind, the intent of the Draft National Children's Mental Health and Wellbeing Strategy's (the Strategy) overarching Wellbeing Continuum to shift away from diagnosis-driven approaches and focus on functioning and early intervention is welcome. Unfortunately, the narrative of the Wellbeing Continuum does not appear to be well reflected in concrete Actions. In fact the Strategy's centrepiece, the proposed model of integrated child and family care, appears to be framed largely in a medical model, and neglects to leverage successful community and social programs and therefore does not address the social determinants of mental health. The danger here is a well-intentioned policy, which unintentionally perpetuates the existing gaps in children's mental health services. It is imperative that in its final iteration of the Strategy the National Mental Health Commission (NMHC) explicitly and comprehensively addresses the service gaps in children's mental health.

The Strategy is also strategically linked with multiple reform processes including but not limited to the development of the new National Agreement on Mental Health and Suicide Prevention, the National Preventative Health Strategy, reform of Primary Care in Australia, the development of the National Mental Health Workforce Strategy, the NMHC's Vision 2030, and the next iteration of the National Framework for Protecting Australia's Children. The Strategy must be cognisant of and consistent with these other strategies to ensure coherent strategic direction across the multiple systems that impact child mental health and wellbeing.

This submission provides feedback against selected consultation questions raised by the NHMC, which are systemic in nature. It also highlights gaps in the Draft Strategy and provides recommendations about how the NMHC can address these gaps in delivering the Final Strategy.

[1] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p.195.

Strategy language

Mental Health Australia supports the intent of the Strategy's Wellbeing Continuum to focus on child functioning rather than on diagnosis. The language used is significant because it has potential to signal the shift from a system focused on diagnosis (and therefore deficits) to one focused on functioning and therefore building on strength and resilience.

This shift could be strengthened by using more holistic descriptors related to social and educational function rather than health-related descriptors (such as 'healthy' and 'unwell'). For example, instead of 'healthy', the Wellbeing Continuum may wish to choose language such as 'thriving', which is more reflective of good functioning across social and emotional determinants. In addition, the terminology 'struggling' is value-laden and runs the risk of being misinterpreted as blaming the child. An alternative could be 'experiencing difficulties'.

It will be important for Wellbeing Continuum terms to be tested with health professionals who work with functional terminology (such as occupational therapists) and, most importantly, children and families themselves, to ensure the terms are meaningful to them. The Wellbeing Continuum should also acknowledge that mental health is not a linear process for most people and so a linear representation, although easier to understand, is probably not a realistic depiction.

The Wellbeing Continuum has the potential to make a tangible difference to the way child mental health and wellbeing is perceived. However the practical impact of the Wellbeing Continuum won't be fully realised unless service models are equally holistic in their design, are strengths-based, trauma-informed, and focused on functioning rather than diagnosis from the point of access onwards.

In terms of the use of language in general across the Draft Strategy, Mental Health Australia would advise against the use of the word 'patients' and would instead recommend using the word 'children', where this applies.

Recommendations:

- That terminology used for the Wellbeing Continuum reflects functioning over health status. Professionals well versed in functional language should be consulted to develop options. Children and families should be consulted on language which is meaningful to them.
- That the Wellbeing Continuum diagram be changed to reflect a more non-linear representation.
- That the Strategy refer to 'children' not 'patients'.

Parenting programs

Mental Health Australia supports the Strategy's Action 1.1.c. that Commonwealth, state and territory governments ensure parents and carers are routinely offered evidence-based parenting programs at key developmental milestones for their child. There is good evidence to support the benefits of parenting programs. A systematic literature review conducted by the NHMRC in 2017 concluded that "antenatal and postnatal education and support interventions, delivered by appropriately trained professionals and starting before birth or in the first year of life, can improve cognitive and social development, infant mental health, sleep, preventative care/health-promoting behaviours, parents' knowledge of infant behaviour, and parenting quality and couple adjustment, and can reduce maltreatment."[2]

As the Draft Strategy rightly notes, there is stigma around parenting programs, which may prevent some parents from participating. Offering such programs universally, as suggested, would assist to remove this stigma. Other options to assist parents to engage in these programs could include:

- Co-designing programs and program promotion materials with local parents.
- Ensuring programs take into account the local demographics and offer culturally safe and accessible material relevant to the local community.
- Awareness raising activities, potentially with the use of well-known community champions, about the usefulness of parenting programs for all parents.
- Ensuring parenting programs are integrated with and/or offered alongside existing programs already universally accessed by parents, for example antenatal classes, early childhood check-ups, and kindergarten induction sessions.

There are also other implementation-related considerations, which the Draft Strategy should foreshadow in relation to the universal offering of parenting programs to ensure parenting programs maintain their effectiveness. The Final Strategy should consider the potential increase in parenting program demand, which may require a commensurate increase in parenting program delivery workforce. Governments may need to consider how to support safe workforce growth to address the demand while maintaining the current workforce skill level. In addition, there will be a need to systematically monitor parenting programs to ensure they continue to have a robust evidence base as their use grows.

In addition to parenting programs, Mental Health Australia also welcomes the Strategy's related Action 1.1.a. that state and territory governments implement universal perinatal mental health screening for expectant parents. The recent PC Report outlines a strong case for supporting parents, "particularly at times of major life transitions, such as the perinatal period."[3] The PC Report's Action 5.1 also encourages governments to take coordinated action to achieve universal screening for mental illness for new parents.

In addition to universal screening of parental mental health, Mental Health Australia suggests that social and emotional wellbeing of infants also be universally screened, alongside social challenges faced by the family. Social challenges faced by the family unit can include, for example, mental illness within the family and the experience of trauma within the family. These issues can be useful risk indicators that could trigger prevention and early intervention services.

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[2] National Health and Medical Research Council (2017). *NHMRC Report on the Evidence: Promoting Social and Emotional Development and Wellbeing of Infants in Pregnancy and the First Year of Life*, p.30.

[3] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p.198.

The PC Report's Action 5.2 that "State and Territory Governments should use existing guidelines to expand the scope of voluntary early childhood health checks, such that they assess children's social and emotional development before the enter preschool"[4] does not go far enough. The Final Strategy should outline an explicit action for universal screening of infant mental health and family social challenges from birth of the infant onwards.

Recommendations:

Mental Health Australia welcomes the Draft Strategy's proposal to offer evidence-based parenting programs universally, at key developmental milestones. Mental Health Australia recommends consideration also be given to supporting workforce growth to match a potential increase in parenting program demand and ensuring parenting programs are evidence-based, broadly accessible, and consumer-informed.

Mental Health Australia supports universal implementation of perinatal mental health screening and suggests expanding mental health screening to also include infant mental health from birth onwards and family social challenges.

Model of integrated child and family care

Australia needs a comprehensive system of child and family supports, spanning the continuum from prevention and early intervention through to crisis responses and therapeutic interventions for those with established, serious conditions, including expanding home visiting programs. A centrepiece to this system should be a model of integrated child and family care. However, as it is described, the model outlined in the Strategy appears to be largely diagnosis-driven, offering individualised mental health treatment (rather than holistic and family-focused approaches), and proposed as an extension of current tertiary care system. This approach appears to be at odds with language of the Strategy's Wellbeing Continuum, the expressed intention of which to highlight opportunities to intervene before a child becomes unwell, and to focus on functioning rather than diagnosis.

In order to align the model more closely with the intent of the Wellbeing Continuum, Mental Health Australia recommends shifts in the model's proposed functions, structure, staffing, and funding, as outlined below.

Proposed functions

The Strategy proposes the model of integrated child and family care will deliver:

» Support for children who have complex needs.

» Psychological treatment for anxiety, depression, and emotion regulation.

» Psychotropic medication treatment for anxiety, depression, and emotion regulation.

» Parenting programs.

With the notable exception of parenting programs, these functions are diagnosis-based, individualised, mental health treatment functions. Although these are important services they are only part of a holistic picture of mental health care to support children and families. The risk of designing a model of integrated child and family care with these narrow functions is that they perpetuate current service gaps, aptly explained by Carswell et al as "the lack of

[4] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p.211.

services available to children with issues too complex for primary care but not yet severe enough to qualify for acute admission."[5] Carswell et al offer one diagnosis of the problem, that the gap emerges because the contributing causes and supports are psychosocial in nature, for example relating to employment, housing, alcohol and drugs, education, and social isolation.

In order not to perpetuate the existing gaps, the model of integrated child and family care's functions would need to be expanded to include psychosocial and family supports. Such functions relevant to supporting child and family mental health could include, but are not limited to, holistic family-focused supports; peer activities that support children to heal from trauma; supports addressing violence, and drug and alcohol use; supports related to juvenile justice diversion; and supports which address other adverse childhood events which can lead to trauma.

For example, the PC Report states that "the mental health of parents has a strong influence on the wellbeing of infants and young children."[6] Poor mental health of one family member can affect other family members, and family relationship-related issues can impact on all family members' mental health. It follows that a focus on the whole family is required in order to support children's mental health. There is evidence of the value of family-focused interventions and more holistic support.[7]

However, mental health funding arrangements (for example through the services connected to a GP Mental Health Treatment Plan or the NDIS) encourage service providers to focus intervention on the needs the individual, not necessarily the family unit. The risks of this approach are profound, including:

- A lack of support for family members who may be supporting a person with mental illness.
- A missed opportunity for early intervention to support families before childhood adversity and trauma occurs.
- A missed opportunity to build on the significant resources and resilience families have in relation to a family member with mental illness.

In addition to expanding the model of integrated child and family care to include psychosocial and family supports, it should also cover the spectrum of supports from early intervention to ongoing support and treatment for more serious mental health concerns. In addition, it should have strong linkages with adequately funded but separate tertiary child and adolescent mental health services designed for children in the 0-12 age group.

It will also be important for the integrated model to have strong linkages with organisations carrying out functions clearly related with children's mental health, including child protection, family violence shelters, juvenile justice and diversionary programs, homelessness services, education institutions, and others. This may be enacted through inclusion of services in the hub model directly as part of the multidisciplinary team or through reliable access pathways.

[5] Carswell, P. Rosenberg, S. Levenberg, A & Henderson, G (2019). *Growing up Well in Australia: Addressing Childhood Mental Health and Wellbeing*, p.44.
[6] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p.198.
[7] Carswell, P. Rosenberg, S. Levenberg, A & Henderson, G (ND). *Growing up well in Australia: Addressing Childhood Mental Health and Wellbeing*, p.44.

Recommendations:

Mental Health Australia recommends that the scope of the model's proposed functions be broadened to include:

» Holistic supports across the social determinants of mental health, including those that are psychosocial in nature and family-focused.

» Supports across the spectrum of early intervention through to support for severe conditions, with clear processes for escalation into separate, adequately funded tertiary care where clinically indicated and necessary.

Proposed structure

The Strategy proposes that "implementation of this model would emerge out of and extend current public health services, rather than creating something entirely new."[8] Mental Health Australia acknowledges the need for tertiary care for children aged 0-12 and the lack of tertiary child and adolescent mental health services, also identified in the PC Report.[9] The Draft Strategy is right in identifying that "The current CAMHS [Child and Adolescent Mental Health Services] model means resourcing is absorbed by acute crisis management of older teens, which contributes to a relentlessly high-risk client load for staff and staff burnout."[10] This same issue means children in the 0-12 age group who are seriously unwell but presenting as apparently less high risk than their adolescent peers are effectively triaged out of receiving support through CAMHS. This leads to a situation where children do not receive adequate mental health support until they are in their adolescent years. By this point they experience potentially preventable deterioration of their mental ill-health.

While Mental Health Australia agrees with the concept of building on existing infrastructure, there is a missed opportunity to design a model of integrated child and family care that also provides care and support, which may help to prevent issues escalating to the point where tertiary care is required.

Mental Health Australia recommends instead that the model be collaborative in nature, be grown out of primary and community care, with escalation available into adequately funded tertiary care where required. The collaborative model should be positioned to ensure better connection between and resourcing of mental health and wellbeing supports (including community based supports) and build system, service and referral efficiency.

In other words, the solution to the under-resourcing of current CAMHS is not just to create another CAMHS with earmarked funding for the 0-12 age group (although Mental Health Australia agrees this is also sorely needed). Australia also needs child and family mental health care across the spectrum of supports from prevention and early intervention through to enabling escalation into separate tertiary care.

In fact, the best solution may be that the governance structure of the proposed model of integrated child and family care is regionally variable based on the needs and the strengths of the local community. For example, a recent research report into the evidence of targeted interventions for children and families noted that targeted interventions are effective for children and families that can access services but not in communities with high level of

[8] National Mental Health Commission (2020). *Draft National Children's Mental Health and Wellbeing Strategy*, p.37.
[9] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p.37.
[10] National Mental Health Commission (2020). *Draft National Children's Mental Health and Wellbeing Strategy*, p.37.

deprivation and risk factors. In these areas the research points to interventions that take a whole-of-systems approach.[11] So it may be that some areas would benefit from greater focus on community development-based approaches than health-focused, individualised treatment approaches. In these regions the community sector should be deeply engaged in the governance structure for the model of integrated child and family care.

In order to cover the spectrum of supports required to enhance child mental health and prevent serious mental illness, implementation of the model of integrated child and family care should be grown out of the current primary and community care systems, with an option for escalation into adequately funded tertiary care if required.

Finally, the Strategy proposes that GPs refer children and families to the model of integrated child and family care. This should be expanded to include referral from community services, adult tertiary services, child care and education providers, and children and families themselves. This would remove unintended barriers to children receiving the support they require. For example, adult tertiary mental health services could identify where a parent has a mental illness that a child may need support (the Strategy's Action 2.2.e). There should be an option for direct referral rather than requiring children and other family members — already working through managing a parent's mental illness — to jump through the administrative hurdle of attending a GP appointment if this is not necessary.

Recommendation:

The model of integrated child and family care should be:

- Grown out of the primary and community care systems (not the tertiary care system).
- Regionally variable to build on local strengths and address local needs effectively.

The referral process into the model of integrated child and family care should be opened up to include referrals from adult tertiary care, community-based organisations, child care and educational settings, and children and families themselves.

Proposed staffing

The model of integrated child and family care proposes a "multidisciplinary team consisting of child and youth psychiatrists, paediatricians, psychologists, mental health nurses, occupational therapists, speech pathologists, physiotherapists and social workers."[12] Mental Health Australia welcomes the multi-disciplinary and potentially team-based approach represented by the envisaged range of allied health professionals proposed to be included in among staff.

Mental Health Australia also welcomes the model's stated intent that the "multi-disciplinary centralised model of service delivery mirrors the holistic approach taken by Aboriginal Community Controlled Health Organisations."[13] The above-mentioned staffing profile does, however, fall slightly short of this intent. In order to provide a holistic service, the model would also need to encompass other community-based workers that provide psychosocial and family supports, for example peer workers and family support workers, drug and alcohol workers.

[11] Carswell, P. Rosenberg, S. Levenberg, A & Henderson, G (ND). *Growing up well in Australia: Addressing Childhood Mental Health and Wellbeing*, p.47.
[12] National Mental Health Commission (2020). *Draft National Children's Mental Health and Wellbeing Strategy,* p.36.
[13] National Mental Health Commission (2020). *Draft National Children's Mental Health and Wellbeing Strategy,* p.37.

Recommendation

The proposed staffing profile for the model of integrated child and family care should be expanded to include community-based workers who deliver psychosocial and family supports.

Proposed funding

Mental Health Australia has serious concerns about the Draft Strategy's suggestion that funding the model "might involve quarantining (and increasing) some of the resourcing currently allocated to CAMHS and child development services."[14] The PC Report noted the long waiting lists and scarcity of child-friendly tertiary services. It outlined the risks associated with alternatives to child mental health specific tertiary services including children being treated in:

- Adult mental health wards, where adult patients may pose a safety risk to children.
- Paediatric wards, where staff may be insufficiently skilled to treat mental health.[15]

Mental Health Australia welcomes Action 2.3.a. that Commonwealth, state and territory governments should increase resourcing for public mental health services. However, this should not be attached to implementation of the model of integrated child and family care as the Action suggests. Instead, as stated in our pre-budget submission, Mental Health Australia strongly recommends that new funding is required to both:

- Adequately fund child and adolescent mental health services to address need.
- Establish the model of integrated child and family care proposed by the strategy.

Mental Health Australia strongly advises against quarantining existing funding sources of an already chronically underfunded system. This should be clearly ruled out in the Final Strategy.

Recommendation

The Strategy should include Actions suggesting new funding should be provided to:

- Adequately fund child and adolescent mental health services to address need of children in the 0-12 age group. New funding should be quarantined for this purpose.
- Establish the model of integrated child and family care proposed by the Strategy.

Mental health workforce

Mental Health Australia supports all actions under Objective 2.5: Skilled workforce, and Objective 3.3: Well-equipped educators. These actions are largely focused on upskilling the current workforce — a necessary and important task — rather than growing the workforce to meet demand. Mental Health Australia welcomes Action 2.5.g. that Commonwealth, state and territory governments "develop workforce projections in the public sector based on evidence and epidemiology and use these to inform further recommendations." This process should take into account work already undertaken by the Productivity Commission Inquiry

[14] National Mental Health Commission (2020). *Draft National Children's Mental Health and Wellbeing Strategy,* p.37.
[15] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p.610.

into Mental Health, which offers recommendations in relation to key mental health workforce shortages and work undertaken by the NMHC and the Department of Health on the National Mental Health Workforce Strategy.[16] In addition, key tools designed to support workforce and service planning could be leveraged to support workforce planning, such as the National Mental Health Service Planning Framework and the Atlas of Mental Health Care.

In order to provide the underpinning workforce required to sustainably improve the mental health of Australian children, the Strategy should also consider broadening the focus of Action 2.5.g. described above, to include the community mental health workforce and envision the workforce growth that will be required to match demand. For example, as outlined above, universal offering of parenting programs is likely to grow the need for community-based workers to deliver the programs. Expansion of the model of integrated child and family care to also deliver psychosocial supports will require growth in the community workforce delivering these supports.

The PC Report recently recognised community mental health and support workers as "a crucial linchpin in supporting the recovery of people with mental illness and their capacity to remain active, connected and contributing within their family and community."[17] However, the report also stated that "it can be difficult to encapsulate the role of community mental health and support workers, particularly because there are no predictable education pathways into the sector and their role can vary substantially between service providers."[18] This may partly explain why the Strategy has chosen not to focus on community-based child and family support service workforce development. These data gaps perpetuate a negative cycle, impeding the ability of planners to measure the current status of the workforce, let alone design its future growth.

Recommendation

The Strategy Action 2.5.g. should be expanded so that Governments develop workforce projections across public, private and community sectors that impact directly on child mental health. This process should be included in the National Mental Health Workforce Strategy, draw on recommendations from the recent PC Report, and leverage existing tools such as the National Mental Health Services Planning Framework and the Atlas of Mental Health Care.

Education

Mental Health Australia agrees with the intent of the Actions outlined under Focus Area 3 to enlist a universal and non-stigmatised system, i.e. early childhood services and schools to assist in early identification of mental ill-health, and build social and emotional wellbeing among children. However, the Strategy is not as clear on where children might be referred to once the education setting identifies that they may benefit from support.

If Mental Health Australia's above-mentioned recommendations in relation to the model of integrated child and family care are heeded, this may provide one option for referral from the education setting. The Strategy could also recommend investment in targeted responses which are embedded within and around education settings. There are existing

[16] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, Chapter 16.
[17] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p. 733.
[18] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*, p. 735.

evidence-based mental health interventions run through education settings,[19] which are available to varying degrees across the jurisdictions. The Strategy should explore the benefits of enabling regionally variable approaches to the model of integrated child and family care, some of which could include a combination of services delivered directly by the model of integrated child and family care itself and services which are embedded in and around the education setting. This should be considered across all schools and not limited to government schools only.

In addition, the Draft Strategy appears to have a much stronger focus on the role of primary schools than the role of early childhood education services. For example, Action 3.2.a. proposes that State and Territory Governments require all early childhood 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 priority for their students. This is also reflected in the intent of the PC Report's Action 5.6, although the terminology used differs slightly. The Strategy Action 3.2.b. proposes that Commonwealth, state and territory governments make funds available to schools to implement quality improvement activities related to student mental health and wellbeing, however there does not appear to be a corresponding recommendation to assist early childhood centres to undertake the same activities. Likewise, Action 3.3.c. requires the employment of specific wellbeing coordinators in primary schools to be responsible for planning and coordination of wellbeing activities, but in early childhood learning, Action 3.1.b. requires existing senior staff to take on this role.

Although the difference in sheer volume of early childhood centres as compared to schools should warrant a differing policy approach, the practical fact remains that neither early childhood educators nor teachers can implement such programs effectively without paid, protected time available to do so.

Recommendation:

That the Strategy:

- Consider alternative Actions to better support early childhood learning settings with paid protected time to implement the wellbeing plans outlined in Action 3.2.a.
- Consider enabling regional variation of the model of integrated child and family care to include delivery of some services through education settings.

Connecting with children and families who are struggling

Mental Health Australia supports the Strategy's approach to early identification of mental health concerns via non-stigmatised and universal services such as education and health settings. It will be critical for frontline workers to build trusted relationships with children and families in order to make this early identification, and subsequently for children and families to engage with the service system.

People who have a disability or mental illness, or who have been engaged in the child protection and/or justice systems are likely to be cautious about engagement with government-funded services due to the experience of being involuntarily treated or otherwise negatively impacted by these government-run services. Some may be deeply

[19] Carswell, P. Rosenberg, S. Levenberg, A & Henderson, G (ND). *Growing up well in Australia: Addressing Childhood Mental Health and Wellbeing*.

traumatised through the process. Therefore, trusted relationships are central to effective engagement. Only once genuine rapport is built can service provision commence in earnest.

Mental Health Australia therefore welcomes Action 3.2.d. that state and territory governments should establish and implement trauma-informed procedures for responding to students disengaging from education. This should apply from early childhood onwards and include not only addressing students disengaging from schools but also other signs that children might be experiencing adverse events. The procedure should be accompanied by training for educators about how to have safe, trauma-informed conversations with children and families.

Improving the safety of children and enhancing family safety and relationships can be a key contributor to positive mental health outcomes. In 2015, the Blue Knot Foundation estimated 1.04 million Australians were facing negative life outcomes (including significant mental health impacts) because of child abuse and neglect.[20] The costs to governments as a result of the impact of unaddressed or inappropriately addressed childhood adversities and trauma are substantial.[21]

Research indicates the impact of childhood trauma can be resolved through appropriate treatment, services, and support.[22] However, the current mental health system does not adequately address complex trauma. Complex trauma often goes unrecognised, misdiagnosed, or unaddressed and consumers are required to tell their story multiple times to an array of uncoordinated services. This only compounds their experience of trauma.

The Section 2.4, 'Built for Complexity', acknowledges the relationship between adverse childhood events, trauma, and mental ill-health. The Strategy's corresponding actions address care coordination, requiring relevant services to give priority access to children who are in state care and requires all government departments to report on what they do to support children in state care.

Although the above-listed actions are welcome, they are far from sufficient to make a significant change to mental health outcomes for children who experience adverse childhood events. To achieve this would require action across the social determinants of health, for example through strengthening economic support for families, promoting social norms that protect against violence and adversity, and connecting children with caring adults.[23]

There is also a need for stronger supports to assist children through recovery from trauma. The Australian Association for Infant Mental Health advises that "If the infant's primary caregiver can be helped to be safe and responsive to the child every effort should be made to support this. If this is not possible then another caregiver who is able to provide the ongoing emotional support and care will need support to connect with and nurture the infant."[24]

There is a clear need for the Strategy to enhance its actions designed to address adverse childhood events and trauma. This should include thorough consultation with the range of services designed to assist family functioning, and in particular with children who have

[20] Kezelman C, Hossack N, Stavropoulos P (2015). *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*.
[21] Kezelman C, Hossack N, Stavropoulos P (2015). *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*.
[22] Kezelman C, Hossack N, Stavropoulos P (2015). *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*.
[23] National Centre for Injury Prevention and Control (2019). *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*.
[24] Australian Association for Infant Mental Health Inc. (2016). *Helping infants through trauma after family violence: Guidelines*.

experience in being in the care of the state, the care providers and families that support them, and their parents and/or wider family.

Recommendation:

The Strategy should:

- Include an action that frontline workers in service settings that assist in identifying children and families for referral to mental health services be trained in building rapport and having safe, trauma-informed conversations with children and families, during which complex issues may be disclosed.
- Outline a suite of actions across the social determinants of health which focus both on preventing adverse childhood events and trauma, and recovering from trauma once an adverse event has occurred. This should include but not be limited to leveraging and better connecting with existing services, which operate across the social determinants of mental health.

Mechanisms for data capture and use

Mental Health Australia supports all actions outlined under Focus Area 4.

In relation to Objective 4.1, Meaningful data collection, Mental Health Australia particularly welcomes Action 4.1.a., the expansion of the Perinatal National Minimum Data Set to include indicators of mental health screening in the weeks before and immediately after birth and Action 4.1.b., to establish a national system for pooling key information related to child mental health gathered via routine development checks or vaccinations during the preschool years. There is a wealth of data already collected via both the education and health sectors, which could be leveraged to better inform policy decisions about child and family mental health. It may be, however, that data for some age groups is not yet as comprehensive as it could be (for example, mental health and wellbeing data for children in the 0-4 age group). Pooling data nationally will enable such data gaps to be uncovered and addressed.

In relation to Objective 4.2, Embedded evaluation and feedback, Mental Health Australia strongly supports Actions designed to encourage service evaluation and enlist child and family feedback as central to this process. Equal weight should be placed on both adequately funding and undertaking evaluation in both clinical and non-clinical settings. In addition, in relation to Objective 4.3, High quality research, Mental Health Australia perceives a specific gap in research around children's mental health in the 0-4 age group. This should be emphasised as a priority area for research in the Strategy.

It is of course imperative that data, evaluation, and research is also transparent and therefore made publicly available. This supports the sector to share best practice, understand the service system and demographics and ultimately design services that better meet community needs. Mental Health Australia therefore welcomes Recommendation 4.2.d. that Commonwealth, state and territory governments openly communicate the evaluation results for child mental health and wellbeing programs that are being delivered, including both positive and negative outcomes. Mental Health Australia recommends that similar transparency-related actions be required across all data, evaluation, and research undertaken into child mental health and wellbeing, as far as is practicable.

In relation to monitoring the effectiveness of implementation of the strategy itself, Mental Health Australia welcomes the Strategy's intent to have open and transparent indicators of

change against which progress can be measured. However, some current draft indicators pose difficulties both in measuring and reporting on progress for change. Consideration should be given to existing data sets available to measure the proposed indicators for change.

Recommendation:

The Strategy should:

- Expand Action 4.1.a. to also include expanding the Perinatal National Minimum Data Set to include data about infant mental health and wellbeing.
- Include a new action, building on Action 4.1.b., tasking the Inter-Departmental Committees proposed by the Strategy with identifying gaps in child mental health and wellbeing data nationally and jurisdictionally once it is pooled; and addressing these gaps.
- Outline a specific action designed to address the gap in research in mental health and wellbeing of children in the 0-4 age group.
- Include revised indicators for change which are specific and measurable to enhance the possibility of transparent reporting against progress in its implementation.
- Include actions related to ensuring transparency around child mental health and wellbeing data, evaluation and research.

Improving the mental health and wellbeing for all Australian children

Mental Health Australia welcomes all Strategy recommendations designed to support the unique needs of children with disability, Aboriginal and Torres Strait Islander children, children from culturally and linguistically diverse (CALD) backgrounds, and children residing in rural and remote locations. However there is a serious omission in relation to children and families who are part of the LGBTIQ+ community.

LGBTIQ+ populations are more likely to experience a mental health disorder, attempt suicide, and complete suicide than the rest of the population.[25] LGBTIQ+ Health Australia states that "These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse" related to their being part of the LGBTIQ+ community.[26] This is also true for children who are a part of this community.

For example, the Melbourne Royal Children's Hospital's *Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents* points out that "some trans and gender diverse individuals express gender diverse behaviour from a very young age, whilst others do not express a trans or gender diverse identity until adolescence or adulthood. The clinical needs of these groups are inherently different…" and that for children there is growing evidence that "family support is associated with more optimal mental health outcomes."[27] Even if children do not consider themselves a part of the LGBTIQ+ community, their parents may be and we know that parental and child mental health is intrinsically linked. Therefore, it is important that the Strategy outline specific

[25] LGBTIQ+ Health Australia (2020). *Snapshot of mental health and suicide prevention statistics for LGBTI people*.
[26] LGBTIQ+ Health Australia (2020). *Snapshot of mental health and suicide prevention statistics for LGBTI people*, p.2.
[27] Royal Children's Hospital, Melbourne (2017). *Australian Standards of Care and Treatment Guidelines For trans and gender diverse adolescents and children*, p.9.

actions to ensure the specific needs of LGBTIQ+ child and family mental health is supported through inclusive early childhood, school and mental health service environments.

In addition the needs of children from culturally and linguistically diverse (CALD) communities must be more robustly addressed in the Final Strategy. CALD children and families have unique experiences of mental ill-health. Issues that impact mental health can include trauma from migration experiences, particularly people from refugee backgrounds; and intergenerational issues arising from cultural transitions and acculturation, racism, and differing explanatory models of understanding mental ill-health. Refugee children may suffer from trauma resulting in poor sleep, aggression, and becoming overly withdrawn, among other symptoms. Risk factors in the perinatal period can include lack of family support, poor English proficiency leading to reduced access to information and support, and the impact of trauma on parenting.

People from CALD backgrounds also face unique barriers to accessing the service system. These include poor English proficiency, lack of familiarity with the Australian health system, and fears about confidentiality. Strategies to mitigate these factors include providing culturally relevant information such as guides to services, and ensuring the regular use of professional interpreting services. Schools as community centre models are also effective ways of providing gateways to health services and are viewed by CALD communities as acceptable and non-threatening ways to access information and support. It is also important for stigma-reducing campaigns to address the specific root causes of stigma in CALD communities and for parenting programs to be culturally appropriate. Ensuring relevant services adopt the Framework for Mental Health in Multicultural Australia is a good starting place to build culturally appropriate services.

The Strategy rightly recognises the importance of Aboriginal and Torres Strait Islander self-determination in relation to the design, implementation, and evaluation of services to meet the needs of Aboriginal and Torres Strait Islander children and families. This is particularly important given the intergenerational trauma, institutional racism, and high prevalence of mental health conditions and suicide experienced by Aboriginal and Torres Strait Islander people. It is also important for child mental health and wellbeing policy related to Aboriginal and Torres Strait Islander children and families to be self-determined. Accordingly, Strategy actions in relation to Aboriginal and Torres Strait Islander children should be designed through thorough consultation with key Aboriginal and Torres Strait Islander organisations, such as Gayaa Dhuwi (Proud Spirit) Australia and Aboriginal and Torres Strait Islander children, families, and communities. It should also take into account existing related Aboriginal and Torres Strait Islander policy including the Gayaa Dhuwi (Proud Spirit) Declaration, the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

The Strategy points out that children with disabilities are at significantly higher risk of mental illness and clearly outlines specific challenges for children experiencing disability and mental illness.[28] It also points out that "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 underfunding of) specialist services that offer expertise in both mental health and intellectual disability." Unfortunately, these clear descriptions of the issues do not flow through to clear recommendations for action. Action 2.4.d. requires 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. Given the high co-morbidity of mental ill-health among children with disabilities, the NMHC should consult with the disability sector with the aim of including more tangible and

[28] National Mental Health Commission (2020). *Draft National Children's Mental Health and Wellbeing Strategy,* pp.15 & 46.

comprehensive actions including investment in services designed to support children with co-morbid disability and mental illness in the final Strategy.

The Strategy rightly points out the lack of mental health and wellbeing services available to children in rural and remote areas and the lack of training and other supports available to mental health-related workers in rural and remote areas. Mental Health Australia supports Action 2.5.d. that training opportunities be created and incentivised for mental health professionals to work in regional and remote areas. This should be considered in the context of the National Mental Health Workforce Strategy.

Recommendation

The Strategy should:

- Clearly outline a plan of action in relation to the mental health and wellbeing needs of children and families who are part of the LGBTIQ+ community, developed in consultation with the LGBTIQ+ community.
- Ensure all Strategy recommendations in relation to Aboriginal and Torres Strait Islander children are thoroughly consulted on with relevant Aboriginal and Torres Strait Islander organisations, children, families and communities.
- More thoroughly address the needs of children and families from culturally and linguistically diverse communities. Children's and young people's mental health services should be required to implement the 'Framework for Mental Health in Multicultural Australia.'
- Outline specific actions to address the needs of children with disabilities and their families, after consultation with children with disabilities and their families.

Communication about the Strategy

It will be important for the NMHC to communicate effectively with children, their families, service providers, and government officials about the Strategy. The Commission should carefully consider the audiences it would like the strategy to reach and the purpose for communicating about the Strategy with each audience as this will inform the appropriate communication method and style. Information about the Strategy should be accompanied by information about tangible actions the Government is planning to take in response to the strategy. The NMHC should also leverage existing effective communication channels, for example peak bodies, community organisations, and health services have wide networks which can help to distribute information.

Conclusion

Mental Health Australia supports the Strategy's approach to child mental health across families, mental health services, education and data, and research and evaluation. Mental Health Australia also supports the intent of the Strategy's Wellbeing Continuum to shift away from a diagnosis-driven approach to instead focus on the child's functioning. However as outlined throughout this submission, the intent of the content of the Strategy and Wellbeing Continuum in particular is not tangibly reflected in the comprehensive list of actions. This submission has therefore outlined a range of recommendations designed to strengthen the Actions to meet the current and future significant challenges of Australian children's mental health and wellbeing. These recommendations will assist the NMHC to design a Strategy that influences governments to build the mental health system Australian children need: a comprehensive system of child and family supports, spanning the continuum from prevention and early intervention through to crisis responses and therapeutic interventions for those with established serious conditions. A system that prevents mental ill-health and prioritises early and effective support in the community. A system that addresses issues across the social determinants of health, that is trauma-informed, recovery-oriented, and co-designed with children and families as its fundamental premise.

Mental Health Australia encourages the NMHC to continue to build on its substantive work on the Strategy to date, including through robust consultation, to develop a Final Strategy, which will be integral in shaping optimal mental health and wellbeing support for Australian children into the future.

Mental Health Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent national representative body of the mental health sector in Australia.

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