The National Children's Mental Health and Wellbeing Strategy

A submission to the:
The National Mental Health Commission

Prepared by:
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yourtown services

yourtown is a national organisation and registered charity that aims to tackle the issues affecting the lives of children and young people. Established in 1961, our mission is to enable young people, especially those who are marginalised and without voice, to improve their life outcomes.

yourtown provides a range of face-to-face and virtual services to children, young people and families seeking support. These services include:

- **Kids Helpline**, a national 24/7 telephone and on-line counselling and support service for 5 to 25 year olds with special capacity for young people with mental health issues
- **My Circle**, a purpose-built, scalable social media platform that provides young people with an easy pathway to anonymous, clinically guided peer-to-peer support
- Mental health service/s for children aged 0-11 years old, and their families, with moderate mental health needs
- **Expressive Therapy interventions** for young children and infants who have experienced trauma and abuse or been exposed to violence
- **Parentline**, a telephone and online counselling and support service for parents and carers'
- Accommodation responses to young parents with children who are at risk and to women and children seeking refuge from domestic and family violence
- **Young Parent Programs** offering case work, individual and group work support and child development programs for young parents and their children
- **Employment and educational programs and social enterprises**, which support young people to re-engage with education and/or employment, including programs for youthful offenders and Aboriginal and Torres Strait Islander specific services.

Kids Helpline

Kids Helpline (KHL) is Australia's only national 24/7, confidential support and counselling service specifically for children and young people aged 5 to 25 years. It offers counselling support via telephone, email and via real time webchat. In addition, the Kids Helpline website provides a range of tailored self-help resources. Kids Helpline is staffed by a paid professional workforce, with all counsellors holding a tertiary qualification.

Since March 1991, children and young people have been contacting Kids Helpline about a diverse group of issues ranging from everyday topics such as family, friends and school to more serious issues of child abuse, bullying, mental health issues, drug and alcohol use, self-injury and suicide.

In 2020, Kids Helpline counsellors responded to over 175,000 contacts from children and young people across the nation, with an additional 1.4 million unique visitors accessing online support resources from the website. In 2018, Kids Helpline made its 8 millionth contact response.

Introduction

yourtown strongly welcomes the development of the National Children's Health and Wellbeing Strategy (the Strategy) by the National Mental Health Commission (the Commission). We provide a range of services – both virtual and face-to-face – to support children under 12 and their families and we have long raised our concerns about the lack of appropriate mental health services tailored to meet the needs of this cohort.

By targeting children with effective policies and interventions, there are significant opportunities to prevent and reduce the escalation of mental health issues and the considerable, detrimental, social and economic effects that they have on individuals over the life course, as well as on their families and communities. Intervention early in life is particularly important for a child's mental health because it is during childhood that foundational resources and conditions for a fulfilling and productive future are created.[1] Given that mental health issues can impede education (including attainment and school engagement[2]), employment and relational outcomes, it is critical that more is done to support the mental health of our youngest generations to prevent lifelong issues from developing with increasing levels of social exclusion.

Furthermore, although highly susceptible to mental health issues and a key at risk group,[3] young brains are highly malleable and responsive to treatment and learning new skills and there are opportunities to optimise the effectiveness of prevention and effective management of mental illness through targeting this cohort. With mental health issues typically starting in people's younger years and half of all lifetime mental illnesses develop before the age of 14,[4] Australia has a significant opportunity to address its rising prevalence of poor mental health and this Strategy delivers much hope.

Our largest service, Kids Helpline, plays a unique role in the mental health system by supporting children aged 5-12 (and young people aged up to 25) who – as the Strategy recognises - cannot access support given the dearth of services, long-waiting lists, unaffordable service costs, age-exclusionary service eligibility requirements and since the system is confusing and complex system to navigate and access. As a result, government departments, headspace and other community services refer children to Kids Helpline and over our 30 years of service Kids Helpline has become a trusted partner of children and young people. Contacts from children under 12 to Kids Helpline represent 17% (21,849) of all contacts to Kids Helpline, and 16% (14,779) of all counselling contacts.[5] Furthermore, 15% of their concerns relate to mental health, 10% to suicide-related concerns and 6% relate to self-harm; it is clear that this cohort are in need of more support and this Strategy.[6]

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[1] Purcell, R. Goldstone, S. Moran, J. Albiston, D. Edwards, J. Pennell, K. and McGorry P. (2011). Toward a Twenty-First Century Approach to Youth Mental Health Care. International Journal of mental health. 40(2),72-87.
[2] E.g. Orygen Youth Health Research (2014) Tell them they're dreaming: Work, Education and Young People with Mental Illness in Australia.
[3] E.g.: Orygen, The National Centre of Excellence in Youth Mental Heath and headspace, National Youth Mental Health Foundation. The submission to the Productivity Commission's Inquiry into Mental Health (April 2019)
[4] Kessler, R.C., Berglund, P., Demler, O., et al. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archive of General Psychiatry 62 (6).
[5] Other contacts to Kids Helpline are recorded separately from counselling contacts and are from children and young people seeking information, referral or who may be 'testing' the service.
[6] Kids Helpline data from 2020

The trust Kids Helpline has developed with children and young people has been built upon a service designed in response to young people's preferred modes of service access, and today they can engage with Kids Helpline counsellors via telephone, webchat, email, online counsellor-facilitated peer support (My Circle) and the Kids Helpline website. Freely available, 24/7 and offering control over what information they disclose and when, children feel less daunted engaging with professional support through these channels.

Recently, the outbreak of the pandemic and subsequent lockdowns have further highlighted the importance of digital services to this cohort, with Kids Helpline demand increasing by 113% for children aged between 5-9 and by 37% for children aged between 10-14 between April and September 2020.[7] Our youngest generations engage seamlessly with online platforms and tools, and although we are greatly encouraged by the Strategy's stated action to increase funding for public mental health services to children to improve access and equity, Online support has a key role to play in achieve this objective and should receive greater focus in the Strategy therefore.

We are delighted to see the Strategy's acknowledgement of the importance of families and the need to provide them with support also, and of the social determinants of health and the need to address factors such as poverty, homelessness and parental alcohol and drug use if a child is to make sustainable progress to improving their mental health. We know that there is little point working solely with a child to support their mental health, if they are only to return home to a family environment that has not changed and addressed the many issues that have resulted in the child's poor mental health.

However, we would like to see the delivery of support to the families of children focused on how it meets the child's needs, which should be of paramount concern, as well as much greater detail on how families experiencing disadvantage will be better supported to address the challenging life circumstances that underpin their child's poor mental health and wellbeing. As we explain in our submission, key to the latter, will be the holistic and universal needs assessment of a child and their family at key stages of a child's life.

Finally, in various places the Strategy mentions the need to co-design with children and families in the design, delivery and evaluation of services and research. We would like to see children and families consulted on this Strategy and on all aspects of health policy and service delivery into the future.

Overall, we are greatly encouraged by the Strategy and its contents, and pledge to support its successful design and implementation. We are happy to meet with the Commission or provide further information where we have provided feedback and suggestions.

[7] Compared to the same period in 2019

yourtown submission

Our submission works consecutively through the Draft Strategy and provides feedback to sections and/or proposals where we have comments.

Principles

yourtown broadly supports the eight principles that underlie the four focus areas of the Strategy. We strongly welcome the 'needs based, not diagnosis driven', principle given the barriers many children and families encounter in seeking a diagnosis (e.g. cost and time) as well as the lack of support options for those who do not have a diagnosed condition. However, we would ask that the Commission considers the following points in the further development of the principles:

- **Child-centred.** In this principle, we suggest an explicit mention of how a child and their needs are at the centre of all decisions and activities undertaken, with their best interests guiding interventions directed at, or the involvement and support of parents, families and communities.
- **Equity and access**. Given the importance of employment to an individual or family's mental health and wellbeing, we suggest 'access to employment' be included in this principle.
- **Universal system.** The importance of the system's ability to respond to the universal – or holistic - needs of children need to be reflected under this principle. In addition, for the system to become universal, system-wide and organisational workforce development, training and cultural change is required and we consider these elements should be captured under this principle.

The wellbeing continuum

There are many aspects of the proposed wellbeing continuum that **yourtown** supports, including the move to use more simplified language and its attempt to reflect a range of experiences clearly and succinctly. We support its shift away from mental health diagnoses to a broader idea of wellbeing, which includes a focus on prevention and early intervention.

yourtown suggests the proposed model should be further nuanced to reflect the range of children's experiences in relation to mental health and wellbeing.

For example, it is not clear why children who are 'coping' and who are therefore 'equipped with the mental resources to manage challenges to their mental health' are not healthy given many healthy children will experience such challenges and have acquired or developed ways to overcome or live with them. At the same time, it may be possible that children confronted with these challenges may need support and may have sought it out and are 'coping', but this nuance is not reflected as a possibility in the continuum. At the other end of the spectrum, a child is deemed 'unwell' in view of a diagnosis and the level of support they need but in reality they could be high functioning, having the appropriate supports in place to ensure that they are well.

The description of those children who are 'struggling' is also not appropriately phrased as it seems to imply some lack of ability in that 'they are not managing these effectively', and hence better

phraseology would be 'children experience challenges to their mental health that require additional support to effectively manage them'.

From a practical perspective, a **continuum of needs** might be a more suitable approach. This approach would set out the range and level of needs and support required and help drive a cultural shift away from the current acute, crisis and diagnosis-led support system response to an early intervention and prevention system designed to support good mental health and wellbeing. It would also ensure that children receive the support they need when they need it. This would better reduce stigma as no labels would be attached to people and their health, their 'coping' or 'struggling', but instead they would simply be accessing a range of support based on their need.

Finally, given the lack of research into children's mental health, we suggest that the continuum is regularly reviewed as and when research findings emerge and that children are engaged in the process of its co-development and evolution.

Focus Area 1: Family and community

Objective 1.1 Supported families

yourtown has long highlighted the important influence that families and parents have on a child's development. In our submissions to the Productivity Commission[8] and the Victorian Royal Commission[9] into mental health, we asked that the system take a whole family approach to mental health to reflect how children and young people's poor mental health is often a symptom of the challenging environmental, relational and socio-economic circumstances in which they find themselves. As the Discussion Paper recognises, for children and young people, these circumstances are predominantly influenced by those of their parents and families. Hence, **yourtown** strongly supports the focus and sentiment of, and actions identified in the Strategy to meet this objective.

Indeed, based on this critical interdependence of families and children's outcomes, **yourtown's** family programs take a whole family approach and seek to support the holistic needs of parents and the wider family that impact on a child's wellbeing. We introduced Parentline as a complementary service to Kids Helpline based on a whole family approach. However, critical to the success of this approach is, first and foremost, **a focus on meeting the needs of the child – be they immediate or long-term**. This emphasis is somewhat lost in this objective and needs to be more explicitly acknowledged throughout this objective, but also the Strategy more generally. We therefore ask that all objectives stress this point and clearly set out how actions meet a child's needs. This will act as a continued reminder to services and staff of who the key client is so they can ensure that, and evidence how, their work supporting families, communities and schools etc. continuously puts the child/ren first.

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8 https://www.yourtown.com.au/sites/default/files/document/Social%20and%20Economic%20Benefits%20of%20Improving%20Mental%20Health%20Productivity%20Commission%20-%20submission.pdf

9 https://www.yourtown.com.au/sites/default/files/document/Royal%20Commission%20inquiry%20into%20Victoria%E2%80%99s%20mental%20health%20system%20submission.pdf

Secondly, a whole family approach is based in the need to address the **holistic needs of a child, and therefore family**. Whilst the Strategy acknowledges the social determinants of health on the mental health of children and families, as we set out in detail below, we do not believe that the actions outlined will sufficiently address the scale and complexity of need, particularly of those experiencing deep and persistent disadvantage, whose challenges are affecting the mental health of their children. We therefore ask that the Strategy goes further than simply recognising the impact of the social determinants of health on the mental health of children and families, and consider ways in which the system and services can identify and support children and families experiencing disadvantage early to prevent the development and escalation of mental health needs, as well as the need for other interventions such as child protection services.

Holistic needs assessment and early intervention

Parents are not only a child's first teacher, they are also their first caregiver and thereby play a significant role in shaping the person the child will become and the opportunities in life the child will have.[10] Secure attachment with their parent/s in the early years positively impacts on a child's later development and life chances, with insecure attachment negatively affecting educational attainment as well as social and emotional development. Parents who are living in poverty, with mental health problems or are young are more likely to struggle with parenting and attachment. Good parenting can protect children growing up in disadvantaged settings,[11] accentuating the need for early interventions with high-risk families that support parenting attachment and responsive care.[12] Secure attachment helps children thrive by learning to manage their own feelings and behaviour, improving their confidence, resilience and self-reliance. Conversely, the absence of these relationships paired with poverty, related stress and interconnected issues, often leaves children emotionally ill-adapted to confront key life milestones, negatively affecting their long-term social, educational, economic and health and wellbeing outcomes.[13]

With the cohorts of children and young people with whom we work, we see how the social determinants of health, and in particular how deep and persistent disadvantage, consisting of a combination of issues such as homelessness, parental unemployment, drug and alcohol abuse, interaction with the justice system, domestic and family violence, child abuse, racism and other trauma, causes, contributes to and/or compounds mental ill-health. This is in keeping with wider research showing higher prevalence of mental ill-health in disadvantaged communities,[14] and for example, mental health issues being widespread in cohorts of children and young people in out-of-home-care and those who have left out-of-home-care.[15]

Furthermore, in working with young children and their families, we are aware of how early signs of disadvantage and their outcomes become apparent, whilst research indicates that poverty is correlated with poorer developmental outcomes for children. The Australian Early Development

[10] Duncan, G. and Murnane, R. e. (2011). Wither Opportunity? Rising Inequality, Schools and Children's Life Chances. New York: Russell Sage Foundation.
[11] Gutman, L. M. and Feinstein, L. (2010). Parenting behaviours and children's development from infancy to early childhood: changes, continuities and contributions. Early Child Development and Care, 180(4), 535-556.
[12] Moulin, S., Waldfogel, J. and Washbrook, E. (March 2014). Baby Bonds: Parenting, attachment and a secure base for children.
[13] Ibid
[14] As cited in: https://www.theguardian.com/australia-news/2015/mar/01/large-gap-between-rich-and-poor-areas-in-use-of-mental-health-services-revealed
[15] AIHW (Australian Institute of Health and Welfare) (2018) Child protection Australia 2016-17, Cat. no. CWS 63, Child welfare, Canberra.

Census (AEDC) shows that significant, poorer child developmental outcomes for disadvantaged communities are notable from the first year of school.[16] For example, in Bridgewater, Tasmania, a region in which **yourtown** is developing an early childhood program findings show that first year school-aged children residing in Bridgewater are two to three times more likely to have multiple developmental vulnerabilities compared to other children in the same age range nationally.

Developmental vulnerabilities include physical health and wellbeing, social competence, emotional maturity, language and cognitive skills and communication skills and general knowledge – all factors that can affect the ability of students to engage with and succeed at school, and with peers. These vulnerabilities and the challenges that they present to children trying to make their way through school have an inevitable toll on their mental health, rendering school an anxious and stressful environment as they struggle to fit in, communicate and relate to their peers, teachers, school work and life. At their most extreme, these vulnerabilities can lead to the development of mental health conditions and/or disengagement from school completely, affecting a range of long-term life outcomes thereon.

yourtown case study: San Miguel family centre

We see the effects that disadvantage and trauma have on the children of young parents and their parents' ability to parent effectively in the family programs we deliver across the country. This includes a unique residential family centre (San Miguel in New South Wales) providing support to young parents aged 25 years or younger - often single mothers - and their children who are at risk.

The young parents have commonly been brought up in out-of-home-care and been affected by family violence, drug and alcohol dependence and economic hardship. Demonstrating the intersection of disadvantage and parental and child poor mental health, these issues have come at a cost to the parents' health and wellbeing and their ability to parent effectively, and in turn to the health and wellbeing of their children, who child protection have assessed as being at high risk of harm. We work with both children and parents to provide intensive, holistic and evidenced-informed support to meet their needs, seeking to improve the health and wellbeing of the child and improve the parenting skills and capacity of their parent/s so that the children are kept safe and less likely to (re)enter out of home care.

Supported by a case manager, San Miguel provides young families with a stable home and a broad suite of therapeutic interventions including: child development support, expressive therapy, play groups, social interaction with other young families, counselling and advice, skills for independent living, and access to legal, employment, education and medical support.

yourtown therefore strongly welcomes the actions intended to provide ways to intervene early in a child's life through perinatal mental health screening for expectant parents in maternity services. We note, however, that some parents and often those who are most vulnerable, do not engage with these services and hence different strategies to engage with parents when at hospital for a birth, for example, must be considered. Moreover, it is not clear what support parents at risk of, or

[16] https://www.aedc.gov.au/

who have been assessed with, mental health issues, are to receive. If a parent's mental health condition has stemmed from significant financial stress, for example, and is struggling to put food on the table, it is again not clear how this Strategy will address the cause and ensure they receive the assistance they need.

We maintain therefore that the **needs of children and family should be holistically – including health and wellbeing, educational, economic and housing – and universally assessed at key stages of a child's life so that wraparound support can be provided to them**, which will ultimately prevent needs escalation and the need for crisis intervention such as child protection support. Providing universal assessments will help reduce stigma and optimise early intervention whilst key stages of a child's life include postnatal, primary school, transition to high school, transition to further education, training or employment and becoming parents.

We also support the actions designed to improve early intervention through educating parents and families about child mental health issues through the provision of evidence-based resources, programs and campaigns promoting child mental health support and symptoms. If Australia is to be successful in reducing and preventing child and lifelong mental ill-health, the system must start by ensuring that every child receives appropriate support in their early years (first 1,000 days) and prior to commencing school. Allowing children to start school already significantly disadvantaged from their peers provides the conditions for mental ill-health to occur and, left unaddressed, the gap between their peers and their own development will continue to grow throughout their young lives. Accessing such support requires parental knowledge and engagement and the actions outlined will go some way to equipping parents with the awareness and knowledge they need to advocate for their children. However, for those **parents affected by significant disadvantage, these campaigns will be hard to engage with** as they seek to simply survive from day to day and so **more intensive support will be required.** Below we set out barriers and facilitators to this end.

Engaging families experiencing deep and persistent disadvantage

As the Strategy notes, most parents want the best for their child and this includes parents experiencing disadvantage, with evidence that having children can be the catalyst for social mobility.[17] However, meaningful engagement with parents and/or carers and families living in the most socially disadvantaged communities does come with significant challenges. In our experience, these include:

- **Stigma.** Parents worrying that by asking for help they will be judged negatively, labelled a bad parent and perceived to be struggling[18]
- **Mistrust.** Parents are mistrustful of formal services and fear their children will be removed if they seek help, including in particular First Australian families and those who have experienced removal themselves from parents
- **Anxiety.** Parents who have social anxiety themselves and that do not want to mix with other parents or interact with services or take their children to appointments
- **Service access barriers:**

[17] A. L. (2017). Moving "Up and Out" Together: Exploring the Mother–Child Bond in Low-Income, Single-Mother-Headed Families. *Journal of Marriage and Family, 79*(3), 675-689, 2017

[18] Ipsos. (2016). Talking Families Campaign: Detailed Findings and Technical Report: https://www.qfcc.qld.gov.au/talking-families-research-report#Research-report

    - Complexity of the system and its lack of coordination makes it hard to navigate
    - Parents fatigued and frustrated by previous failed and cyclical experiences of trying to access the system and support they need
    - Lack of childcare and transport (and associated costs)
    - The inverse care law, which in reality sees the most disadvantaged communities the least well-supported, particularly rural and remote communities
- **Disadvantage.** Parents struggling with many other personal and family issues causing stress in the home– such as poverty, unemployment, family violence, past trauma or mental health issues – that make seeing their child's mental health as a priority difficult
- **Frustration.** Parents experiencing fatigue and frustration from having previously tried to engage with the system and giving up on seeking support.

To help overcome some of these barriers to accessing support, we recommend the Strategy includes the following:

- **Present programs as 'family programs'** rather than 'parent/ing programs', which helps to reduce the stigma attached in accessing them and to prevent parents from being immediately on the defensive
- Leverage off the fact that parents do want the best for their children, with this cohort telling is they are keen **not** to replicate the upbringing they experienced for their child/ren, and engage with parents through programs by **promoting how they will help meet their children's needs first and foremost, and support their child's development and outcomes**
- **Acknowledge the journey** that some parents will need to go on to help them realise through making changes themselves they can help their child, and **build sufficient time and sensitivity in service provision to accommodate this realisation**
- **Build on the relationships of existing services** that families know, use and trust through providing mental health support in the form of **roaming mental health practitioners** who are attached to, and regularly service, specific services and areas
- Provide support at **key, trusted and regularly accessed touchpoints in community** – e.g. schools, child health community centres, child care centres
- **Provide outreach services** – both in person and virtual – to remove the barriers of social isolation, social anxiety, stigma, travel and cost from service access
- **Optimise and embed digital resources and support services into the system** – the pandemic has shown us how some of our families prefer online engagement given appointments can more easily fit around their busy family lives and they do not need to travel to them
- Where appropriate/possible, **give parents roles in the service to help engage and empower them** – some parents need to feel they have a purpose when engaging with the service and get a lot out of feeling they are needed by the service and other clients
- **Focus on a family's issues not the service's objectives** – parents are well aware of when services and staff are seeking to fulfil organisational priorities and administrative and funding requirements and feel unvalued when these considerations come first

Finally, further research into how to engage families who experience disadvantage using channels and programs that suit them and their needs is needed as their voices and experiences are underrepresented.

Things we can build on

Parentline

Parentline is a universal, confidential telephone and online service that provides counselling, education and support for parents and carers of children and young people in Queensland and Northern Territory. Over the past 24 years, professional qualified Parentline Counsellors have responded to more than 200,000 contacts and the Parentline website has had more than 200,000 unique visitors.

Parentline supports parents experiencing moments of dysregulation and feelings of overwhelm to build strong healthy relationships with their children and enhance family safety and wellbeing. It plays a critical role in increasing children's wellbeing by supporting parents to enhance protective factors commonly recognised as influential in the prevention of child abuse and neglect. These factors include:

- capacity to self-regulate;
- parenting confidence;
- family connectedness;
- relationship with child;
- understanding of self;
- understanding of child; and
- ability to care for child.

The main reasons parents contact Parentline include challenging behaviour/discipline, parent-child relationships, child mental health, parent mental health and parenting strategies. Further work is needed to develop standardised, more universally accessible models for virtual family support services (across all states and territories), along with the identification of evidence-informed approaches to meet the needs of families.

Objective 1.2 Increased mental health literacy

yourtown supports this objective and the actions proposed to meet it. However, any campaigns and activities developed to increase parents' and carers' understanding of child mental ill-health need to be evidence-based and evaluated. In particular, they must be designed to accommodate the needs of all cohorts of parents/carers, especially those experiencing disadvantage who as noted previously will find it harder to engage with such interventions.

Things we can build on

Parents Corner
In our view, Head to Health will need to be re-developed to ensure that it can accommodate the needs and access preferences of all cohorts of parents and families. Any portal of this nature must use accessible language and seek to be hosted on sites and social media apps which are used by diverse groups. In our experience, parents access Facebook and we have developed a place-based (Deception Bay), closed Facebook group (Parents Corner) in consultation with the parents who use it. Once a week, Parents Corner service users are supported by a child health practitioner who responds to their questions and concerns. Since the outbreak of the pandemic, parents have increasingly looked to Parents Corner for advice and support, and have specifically requested resources on specific topics. Head to Health will similarly need to be co-designed with families with a range of backgrounds and evolve to meet their changing needs.

Objective 1.3 Community-driven approaches

yourtown strongly agrees that the community in which a child grows up influences their life outcomes. Research shows that children from families experiencing disadvantage who live in more affluent communities have greater access to opportunities, encounter a broader range of role models, have better support networks and services, and as a result have better life outcomes.

We therefore support the actions proposed to support this objective, however they are very broad and lacking in detail. They will also require significant investment and resources given the scale of the challenges they are seeking to address. We would like to see more detail in these action points, and to this end, we would be keen to provide input into a process to develop them.

Things we can build on

Communities for Children (CFC)

As the Strategy suggests, collective impact strategies are promising approaches to better supporting the complex needs of communities. For example, the evaluation of the Geelong Project in Victoria, an early intervention place-based partnership aimed at preventing young people at risk of disengaging from or leaving school from becoming homeless and entering the justice system, has reduced youth homelessness by 40%, halved the risk of school disengagement and reduced early school leaving by 20%.[19]

A similar approach underlies the Communities for Children model, for which we are a Facilitating Partner (CfC FP) in Deception Bay, Queensland. To help our cohorts of families access CfC services and overcome barriers such as transport and mistrust of formal services, we use outreach and informal events to help establish relationships of trust, a key foundation needed if families and children are to keep using our services, build trust and make progress. This 'soft entry' to more intensive or targeted services, where we use a range of online activities (e.g. using social media) and face-to-face events (e.g. our fortnightly BBQ at a local caravan park) has proved successful in engaging families who do not typically connect with formal services.

We also piggy-back on universal services, and in particular schools, which have high access rates for many families and where stigma relating to receiving support is reduced therefore. As the CfC FP, we work collaboratively to ensure vulnerable children and families are supported through the CARE program, which is embedded within the three local state schools. The schools/teachers refer children identified with emotional health and wellbeing needs, and their families to this service and the program delivers a case management service supporting the whole family with the aim of enhancing family functioning by; connecting them to relevant supports; improving the child's coping skills and; maintaining their engagement in school. This model was the basis for our CARE Plus program that we deliver in Port Pirie in South Australia which is funded by the Children and Parenting initiative. Delivered in close collaboration with primary schools, the two programs are well placed to provide early intervention to at risk families at risk of engagement in the child protection system.

Finally, we hold regular monthly meetings with all partners in our CfC FP through our Child and Family Alliance initiative and we also encourage those services and programs that are not funded through the partnership to attend. The Alliance supports information-sharing, networking, professional development and builds community capacity through co-ordinated, collaborative responses to identified needs and gaps.

In addition to the characteristics of a successful, place-based approach outlined in the Strategy, we would add:

- **Funding mechanisms** need to facilitate service collaboration, not competition

[19] MacKenzie, D. (2018) The Geelong Project Interim Report: https://apo.org.au/sites/default/files/resource-files/2018/02/apo-nid133006-1208531.PDF

- There are **clear lines of accountability** so that each service knows what they are responsible for and how governance and funding processes operate
- **Consistency of support** is embedded into communities – families often grow disillusioned by pilot or new services popping up and then closing. With relationships and trust so important to this cohort, it is important to establish and embed stability into the community infrastructure.

Finally, whilst we are strong advocates of place-based approaches, we would recommend that the Strategy also considers how communities of different socio-economic characteristics (especially those in close/bordering proximity) can engage with each other and build on each other's strengths to unlock the social agency embedded in each and to help all families thrive and learn from each other regardless of where they live.

Focus Area 2: The service system

yourtown strongly supports the key points made in the analysis of the service system in the Strategy. In our experience of working with and delivering services to children and young people in need of mental health support, we know the system:

- **has long-waiting lists** and, as a result, risks missing optimal times to engage with clients who have reached out for help, as well as an opportunity to prevent and effectively manage needs before they escalate.
- **is cost prohibitive** – for example, Better Access is only subsidised and some families find the gap they must pay unaffordable. In addition, where waiting lists are too long for patients to access publically-funded services, many families also find private services to be unaffordable.
- **has exclusionary eligibility criteria:**
    - The specialist services for children and young people of which we are aware exclude under 12s, being accessible to over 12s only. However, Kids Helpline data from 2020 revealed that 12% of all contacts about suicide were from people aged 12 or under.
    - There is a 'missing middle' whereby the needs of children and young people are either not severe enough or are too severe to be eligible for service support.
- **does not have sufficient capability** to respond to complex needs or to manage crises situations, including post-crisis.
- **is inaccessible**, as, for example, they are face-to-face services. Face-to-face services can be extremely hard to engage with in close-knit communities (e.g. remote and rural communities in particular) due to fears of young people that their contact with these services will become known in the community with resulting risk of stigma and the fear of being judged by people in the community.

Hence, while many services currently provide appropriate services for young people (such as headspace) and there are examples of successful interventions to support them with a range of different conditions (e.g. cognitive or dialectical behaviour therapy), there are simply not sufficient,

free services tailored to their needs and preferences available of all children and young people, but particularly to those aged under 12.

Things we can build on

Kids Helpline

Recognised publically as the national helpline for children and young people and a pillar of the mental health system, Kids Helpline is unique in Australia and internationally and seeks to meet the needs of children and young people aged 5 to 25 'anytime, anywhere, any reason'. Unlike many other helplines, support is delivered by tertiary qualified counsellors. Kids Helpline plays key roles in responding to the mental health concerns of children and young people and to the gaps and issues of the system as listed above.

These include:

1. **Prevention and soft entry.** Children and young people can contact KHL about any issue privately. Clients can **'test'** the service and disclose issues and access formal services **when they feel comfortable.** This encourages help-seeking and builds trust. Counsellors provide psycho-education and facilitate early referral to specialist support.
2. **Front door to support system.** KHL helps clients **navigate the complex and daunting mental systems and services**. Counsellors advise, sign-post and refer clients to community and specialist support.
3. **Safety net.** KHL is a **safety net** to children and young people with **undiagnosed mental health needs and other complex issues**. It prevents clients from slipping through the cracks and **'holds' those waiting to access services** given long waiting lists, service ineligibility (the 'missing middle' and under 12s), after hours or service closure or lockdown.
4. **Case management.** KHL works with clients with high and complex mental health needs on an **ongoing basis**. Counsellors undertake assessments, develop case and safety plans, refer to other support services, participate in case teleconferences and facilitate self-management.

Access to Kids Helpline is via multiple channels driven by young people's preferences for communication, including - phone, webchat, email, online counsellor-facilitated peer support groups (My Circle) and website resources. This accessibility enables children and young people throughout Australia to access professional support – notably including regional, rural and remote communities where we may be the only service available to meet children and young people's needs.

Furthermore, in 2020, 16% of all Kids Helpline counselling contacts (14,779[20]) were from children aged 5-12 years, who use Kids Helpline for support of their mental health needs: 15% of their concerns related to mental health, 10% related to their suicide-related concerns and 6% related to their concerns about self-harm.

[20] Where age is known

Objective 2.1 Improved system navigation

yourtown agrees with the Strategy's summary of system issues relating to navigation. However, we ask that the Commission reviews Action C's proposal to 'establish [a] model of integrated child and family care networked across Australia that provides holistic assessment and treatment for children 0-12 years old and their families'.

We fully support the need for holistic assessment and treatment as described above, noting these to be integral to making progress in prevention and early intervention of mental health needs in Australia. However, given the diversity of Australia's communities in terms of socio-economic demographics and geographic and environmental differences, one model to support system navigation may not sufficiently respond to the different needs of communities. Furthermore, there are safety issues and other concerns for survivors of domestic and family violence or for families who are disputing care arrangements for their child/ren through the family law courts that may make accessing services through a hub difficult.

Rather than invest heavily in one model, we encourage the Commission to identify different models and strategies to facilitate system navigation and accessibility including:

- The **community hub model** as outlined in Box 3 in the Strategy document and which may prove particularly effective (including cost-effective) in specific communities – e.g. certain communities within urban locations or even rural and rural locations.
- Although in an ideal system **care coordinators** would be allocated to every child/family experiencing mental health and wellbeing issues, we fear in reality that cost may prevent this and hence suggest that care coordinators are allocated to families depending on the needs and complexity of issues affecting them.
- The implementation of a **case management approach** within the system supported by the clear identification and incentivisation of a staff member in a service to take responsibility for care coordination (this could be a care coordinator as above) and transitions. Given their intersection, a joint case management approach between child protection, youth justice and mental health services could also be considered.
- As previously suggested, **roaming mental health workers** that are attached to an area or certain services would be a practical way to offer support to families who have formed relationships with a service and their staff and would feel more comfortable to access mental health support more discretely through this service.
- **School phycologists** (could be provided in person or virtually – Kids Helpline undertakes this role currently in some schools in New South Wales) to help identify mental health needs amongst children and support their families to access specialist support and other services if necessary.
- **Improved information-sharing legislation and protocols** to support effective system navigation by ensuring staff are aware of a client's support journey and do not direct them to services they have previously tried to access. A common complaint of our clients is that they are repeatedly advised to access services that previously have not been effective or suitable). Work in this area, must align with other information sharing work underway by the Australian Government including by: i) establishment of a national information sharing

system to protect children from harm by the National Office for Child Safety; and 2) in relation to information sharing and information collection as part of Child and Families grant funding by the Department of Social Services) .

- **Gate-keeper training** that ensures that there is no wrong door to accessing support, and that includes training on trauma and child development. Mental ill-health issues should be effectively identified and supported no matter where people come into contact with key government services including education, police, youth justice, employment, health, housing, domestic violence and other welfare support.

yourtown suggests that services be required (i.e. via funding agreements) to update their details on any portals intended to support referrals. Given the frequency at which services open and close in the sector, referrals lists are regularly out-of-date. Requiring information to be updated would help manage this issue. In addition, those responsible for referring children and families to services should be able to access information about the affordability of services so that free services can be easily identified to families who do not have the funds to pay for support.

Specific reference also should be made to incorporating children's experience and preferences for transitions between services as part of any design process.

Objective 2.2. Collaborative care

yourtown supports the discussion about, and actions seeking to achieve this objective. Our feedback to the previous objective (2.1 System navigation) has crossover and relevance to this objective also.

Objective 2.3 Access and Equity

yourtown strongly welcomes Action A 'increase resourcing for public mental health services to support children age 12 and under'. However, as per our feedback on the development and implementation of one model of integrated care, we ask the Commission to consider resourcing many models and strategies to improve integrated care, as well as a broad range of evidence-based services tailored to meet the diverse needs of this cohort throughout their care and support journey. This includes the optimisation and embedding of digital services into the mental health system (see section below on 'Things we can build on').

Recognising the importance of client-centric, effective and sustainable service design and development, **yourtown** is embedding youth participation and lived experience into our organisation. This work seeks to support the genuine input of our youth participation groups into service design, evolution and staff training. We therefore welcome Action E regarding genuine co-design in the 'design, delivery and evaluation of all services supporting children and families'. In our experience to date, however, youth participation is resource-intensive and has many ethical and logistical processes to think through. We have employed dedicated members of staff to coordinate youth participation activities. Hence, we ask that the Commission considers how best to support mental health services to meaningfully undertake this process, and that it provides, for example, a

youth participation/lived experience framework, guidelines, training and resourcing for these activities.

Things we can build on

Digital services

Our younger generations engage seamlessly with online environments and look to digital services for all types of connections, including support. Indeed, digital platforms and tools provide a range of benefits to children and young people seeking mental health support. For example, they tell us that they turn to Kids Helpline as it helps them overcome the barriers to access, such as stigma and discrimination, cost and transport. They can find face-to-face services daunting and intimidating, and fear they will be judged - for those who live in rural and remote communities in particular as communities are small. Stigma was found to be the main reason that children and young people told us prevented them from actively seeking help in our research with them about suicidal ideation.[21] By offering a layer of anonymity through different modes of access, phone, webchat and email, Kids Helpline clients feel they can overcome the stigma of reaching out for help in relation to mental health issues.

The removal of barriers and the provision of professional support are major contributing factors to contacts to Kids Helpline. Not only does Kids Helpline service a range of ages, including children under 12 who represent 17% of Kids Helpline contacts (with contacts with children aged between 5-9 increasing by 113% between April and September 2020), but it also services children from a range of backgrounds (CALD representing 30% of all contacts, and First Australians representing 5% of all contacts[22]).

Kids Helpline also engages digitally with children through using different strategies and interventions designed to be hosted on social media and other digital channels. For example, Nickelodeon Australia and Kids Helpline teamed up to encourage kids to 'Get Real With Your Feels'. The co-designed online quiz asked children about how they were feeling using a SpongeBob game and talked about getting help at Kids Helpline. Not only did it help children identify and understand their feelings but it also encouraged them to be more willing to open up to family and friends about what was on their mind.

In addition, we provide some high schools in New South Wales with virtual Kids Helpline school counsellor support and believe that we could provide similar services effectively to children in rural and remote communities, where it is likely to remain difficult to attract and retain professional staff and/or provide services cost effectively. Digital counselling services, such as Kids Helpline, should be factored in as part of the system of support to children and young people to increase access and equity.[23]

[21] **yourtown** (2016) Preventing suicide: The Voice of children and young people: https://www.yourtown.com.au/sites/default/files/document/2.%20Preventing%20suicide%20by%20children%20and%20young%20people.pdf

[22] Where cultural background is known

[23] Data taken from contacts made in 2020 to Kids Helpline

Finally, whilst adolescents proved to be more receptive to our transition of face-to-face mental health services to virtual over lockdown and in general engaged well with support using this channel, we nonetheless successfully managed to transition all of our clients who are families to online therapy and support. The benefits of using this delivery mode included being able to respond to a crisis in a timely manner and flexibility in relation to the time of the appointments and sessions, which enabled them to better fit around the lives of families. Where we offer outreach services (e.g. in our federally funded program, Starfish, which provides support to children aged 0-11 years old with moderate mental health needs, and their parents), online services meant staff could be more productive given reduced travel time to and from appointments. In addition, it became clear that digital service provision worked well for clients who felt safe at home and/or where they had space to speak confidentially. Conversely, in some sessions staff became aware that remote service delivery was not suited to the needs of those who did not (e.g. they were not as open, or in cases where we had to have a session by phone, they whispered).

In response to the clear benefits that some families gained through receiving online mental health and other supports online, we have worked to embed the diversification of our service delivery into the organisation, through strengthening our risk assessment procedures in relation to online work and developing guidelines and a range of standard processes and materials. However, we also met with some barriers to providing services digitally and we bring these to the Commission's attention so it might reflect on solutions to overcome or accommodate these issues:

- The **technology not working** or not working consistently including audio, visual or the internet which disrupted therapeutic relationships and the therapeutic process
- Some families **not having access to appropriate technology** (e.g. a computer or camera or sessions)
- Children, particularly those under age of 8, would at times **struggle to focus for long periods** of time online
- As previously mentioned, some clients were confronted by **confidentiality issues** due to limited space or control of the environment at home, and
- Schools stopped counsellors from delivering sessions in the school but did **not have sufficient digital resources or technology privacy policies** (e.g. firewalls) to support students to engage virtually with a counsellor during school hours.

To improve access and equity, mental health services and support systems must employ a range of digital tools to support children and young people, whilst ensuring that they remain up-to-date and relevant.

Education

National research shows that stigma and discrimination are factors playing a role in preventing many children and young people with mental illness from accessing the mental health services

they need.[24] However, we know that educating children and young people works to overcome barriers to help-seeking through our provision of free Kids Helpline @ School sessions and hence is an important part of improving system accessibility and equity (please see more on Kids Helpline @ School in our feedback on Focus Area 3: Education).

Objective 2.5 Skilled workforce

We support the actions identified to meet this objective. In addition, however, reflecting the scale of the proposed reforms and service expansion in the sector, the number of stakeholders involved in its implementation (e.g. federal and state governments, public and private providers, mental health services as well as education, welfare and child protection services etc.) and the need to coordinate the proposed actions, the Draft Strategy should be supported by a workforce strategy, which aims to build capacity amongst the workforce to work:

- with children under 12 and correctly identify symptoms of their poor mental health and respond in developmental appropriate ways
- with families experiencing disadvantage, and know how best to support their holistic needs, including through referral
- using trauma-informed practices
- with digital services, and
- to rebalance the system to prevention and early intervention.

To respond to the Strategy, individual service providers will also need to consider their workforce and ongoing development and develop their own appropriate workforce strategies.

Focus Area 3: Education settings

Like the Commission, we maintain that all educators and education settings have key roles to promote child mental health and wellbeing since:

- Mental health issues commonly first emerge when people are young
- These settings and staff can early contribute to and trigger poor mental health
- They are relatively universal, especially for under 12s and hence reflect prime opportunities to identify and support mental health issues early
- Poor mental health commonly leads to poor educational outcomes, such as lower educational attainment, poorer engagement with study and school and higher drop-out rates.[25]

We therefore welcome the Commission prioritising of education as one of the four focus areas. However, whilst educational settings have high levels of engagement, children and families who do not engage with these services are likely to be the most vulnerable in our communities and in greatest need of support. Hence, school-focused interventions can only be effective if the raft of other community and support service measures are effectively implemented. The goal must be to

[24] Hiscock, H., Mulraney, M., Efron, D., Freed, G., Coghill, D., Sciberras, E., Warren, H. and Sawyer, M. (2019) Use and predictors of health services among Australian children with mental health problems: A national prospective study. Austraian Journal of Psychology.
[25] Australian Government Productivity Commission (2019) The Social and Economic Benefits of Improving Mental Health – Issues paper: https://www.pc.gov.au/inquiries/current/mental-health/issues

ensure that all possible touchpoints that a child and family encounter act as a safety net through being able to identify issues and appropriately engage to provide support or referral.

Objective 3.1 A Wellbeing Culture

In our experience, school environments can too often contribute to poor mental health of students and escalate their issues and conditions rather than support them. For example, our Lived Experience Network of young people with a lived experience of suicide have presented their stories to a group of around 30 educators. During their presentations, common themes emerged with school often;

- a trigger for their suicidal ideation;
- a place where their mental health issues developed or were compounded (through bullying for example);
- a place where they did not feel supported (again for issues around bullying that they felt were simply ignored by teachers); and/or
- a place where they or their friends were inappropriately supported - through highly impersonal risk-management strategies, through teachers taking no personal responsibility for ensuring students with thoughts of suicide actually received the support they needed or following a friend's suicide in their school.

In telling their stories, these young people emphasised the variation in support that they received as they moved between different schools.

In addition, we have received feedback from our staff working with students who have disengaged from school who report that often the effects of trauma and deep and persistent disadvantage are not well recognised or responded to by schools and teachers. Children displaying problematic behaviour at school are often labelled ADHD or dismissed as 'bad behaviour' (without any follow-up care), when a history of untreated, complex trauma is likely to be responsible for their behaviour.

We would urge the Commission to review the actions intended to achieve this objective and ensure that they do not simply become a list of actions that schools seek to merely tick off, but rather they underpin a genuine shift in school culture. Having a skilled workforce is key to driving this cultural change and we support many of the Strategy's actions to this end.

Things we can build on

Kids Helpline @ School

Kids Helpline @ School is an early intervention and prevention program facilitated by Kids Helpline counsellors using videoconferencing technology, available free of charge to all primary schools in Australia and high schools in Northern Queensland through the NQ PHN. The program aims to improve student mental health literacy, resilience and help-seeking skills and session content has been aligned to the Australian curriculum.

In 2020, 263 schools participated in 784 classroom and home-based sessions, engaging 24,864 students. In the same year, in view of the pandemic and the dramatic increase of contacts to Kids Helpline in this cohort (contacts were up by 113% between April and September for children aged 5-9 years), we developed a new topic addressing the anxieties of children in relation to COVID-19. Following feedback through our annual evaluative survey of 1,588 teachers and students, both teachers and students stated that the program had increased student understanding of the issues, and of help-seeking options and would positively influence their future choices and decision-making.

Kids Helpline is a service trusted by children and young people and there are opportunities to capitalise on its reputation and further embed its satellite services, such as Kids Helpline @ School within schools.

Objective 3.2 Targeted Responses

As a youth specialist in education reengagement, **yourtown** sees firsthand the transformational power of education (both academic and vocational) on young people's lives. Obtaining qualifications has the potential to improve a range of life outcomes, including health, wellbeing, social and economic outcomes, as demonstrated by a wealth of research.[26] Education has the power to provide every young person with the opportunity to reach their potential in life, yet their unique set of experiences and needs means that too often young people are unable to fulfil their potential, with unsupported/or escalating mental health issues being a contributing factor.

When families are experiencing multifaceted disadvantage - such as financial hardship, poor housing/overcrowding or homelessness, family conflict or dysfunction, mental health issues or drug and alcohol misuse - children's school attendance and education is likely to suffer.[27] Disadvantaged students are significantly behind in reading and maths, Year 12 completion rates are nearly 20% lower than for students from high SES backgrounds and university students from high SES backgrounds are three times more likely to attend than students from low SES backgrounds.[28]

[26] Waddell, G. & Burton, K. 2006. Is work good for your health and well-being? Executive Summary. Norwich: TSO
[27] The Smith Family: https://www.thesmithfamily.com.au/poverty-in-australia
[28] Ibid

Research findings also overwhelmingly demonstrate that poor educational outcomes lead to poor employment outcomes, whilst financial hardship induces stress and significantly impacts on people's ability to function well in other areas of life, including their mental health. Conversely, higher educational attainment results in improved employment and therefore economic outcomes for an individual, a family and a community.[29] We consider that ensuring children have the right support to effectively engage with their school and education is crucial to underpinning the foundations of good mental health and reducing or managing any mental health issues that manifest during school age.

yourtown has long delivered programs to help children and young people (re)engage with school and currently we deliver Flexible Learning Options (FLOs) in South Australia and the Education Engagement Program (EEP) in Queensland. In working with this cohort of children and young people, we have understood the value of relationship-building to their progress. Hence, investing in developing and nurturing relationships between our clients and our staff, their families and their schools to build mutual trust and respect underpins our work.

However, a frustration in our work in this area is that disengagement starts early, and typically signs of disengagement can be noted in primary school, so that by the time programs such as FLO are provided (from ages 14 upwards), the student has often no pathway back to education due the amount of time out of school. Whilst there will always be some older students who due to changing circumstances require support to reengage with school, focusing on preventing disengagement and intervening early is therefore key.

Furthermore, critical to understanding and enhancing engagement is recognition that engagement with education is not an attribute of the student. Engagement is an alterable variable that is highly influenced by policies and practices of the school and its teachers, as well as by family, peer and community influences. Hence, interventions that aim to improve student engagement with school must not simply focus on 'improving' a child or young person but jointly seek to review and improve school and staff policies and practices to better meet the child's needs also.

Although robust evidence of what works is lacking, from our experience and research it is possible to conclude that effective programs for students who have left or are at risk of leaving school early do the following:

- target engagement, not merely attendance
- start early
- strengthen relationships between students and school staff
- work in partnership with school
- engage families
- provide intensive, long term, individualised, holistic support for both academic and personal issues
- are strengths-based
- are tailored to the local context (school and community)

[29] The Smith Family: https://www.thesmithfamily.com.au/poverty-in-australia

- are framed by a gradual planned reintegration into mainstream school.

In addition to the factors influencing engagement for non-Indigenous Australian students, Aboriginal and Torres Strait Islander students are affected by racism and racially-based bullying, lack of cultural inclusion in schools, and mistrust of education as a result of past and present experiences and past and present government policy. Effective programs for First Australian students need to find ways to address these issues, build trust between schools and Indigenous Australian young people and families, and support them to develop a sense of belonging to their school.

Whilst we are pleased to see the Commission recognise the link between school engagement and mental health in the Strategy, we would ask that more significant thought is given to actions preventing students at risk from disengaging and to their reengagement, with a view to embedding key interventions and approaches (such as those we list above) consistently across schools. We also ask that Action D refers to procedures relating to all students, not just those disengaging from their education.

Objective 3.3 Well-equipped educators

We support the action points set out to achieve this objective. However, given the intersection between mental health and education outcomes, we maintain that it is in the interests of all teachers to know how to identify poor mental health and support it (e.g. both in their immediate response and in knowing where to refer students for specialist support). For this reason, we would like to see teachers undertake modules in child mental health, trauma-informed practice and child development as part of their degree. This addition would also help drive cultural change within schools to better support the mental health needs of students.

Focus Area 4: Evidence and evaluation

yourtown takes pride in the investment that we make into research and evaluation of our services to ensure that they respond directly to the needs of our client groups, and remain effective, relevant and sustainable. We also use our research and evaluation to drive innovation. In recent years, we have developed our niggle app,[30] an integrated mental health services that links a mobile interactive toolkit for self-directed help-seeking with Kids Helpline's more traditional service modalities, and My Circle, a purpose-built, scalable social media platform that provides young people with an easy pathway to anonymous, clinically guided peer-to-peer support.[31] Both of these services respond directly to the rising demand we have seen in Kids Helpline clients' preferences to connect online with the service through webchat and the website, and acknowledge that clients with mental ill-health may not be able to access face-to-face services due to poor self-esteem, anxiety, their condition, cost, transport or the lack of anonymity. Hence, we strongly support the Commission's focus on evidence and evaluation and maintain that this focus is integral to effective system, policy and service design and delivery and the success of the Strategy therefore.

[30] https://kidshelpline.com.au/niggle
[31] https://kidshelpline.com.au/my-circle

We also support the Commission's suggested approach to evidence and evaluation and the objectives outlined in this focus area. Points to consider that are omitted in the section, however, are the relevant federal reviews and reforms taking place currently. These include: the development of the National Child Safety and Wellbeing Information-sharing Scheme (Health), the National Office for Child Safety's Information Sharing project (Prime Minister and Cabinet), the development of the Outcomes Framework for Families and Children Services and associated information sharing objectives (Department of Social Services) and Closing the Gap (National Indigenous Australians Association). Reforms within this focus area should consult and ultimately align with developments in these reviews.

Objective 4.1 Meaningful data collection

We understand the importance of collecting meaningful data and over Kids Helpline's 30 years of service we have modified our data collection and management systems to optimise their assistance in the development and delivery of Kids Helpline. Having responded to over 8 million contacts to Kids Helpline, we have collected significant data relating to children under 12. However, we concur that key population data is missing in this cohort in Australia and is needed to underpin this Strategy and make progress in preventing and reducing childhood and lifelong poor mental health.

We also agree that the difficulties in accessing data across policy departments need addressing, but so too do the difficulties in accessing data across jurisdictions and different organisations (non-government and private). Embedding the diverse perspectives and ways of working of different departments and the states and territories and organisations, and ensuring they feed their data into or that their system links to one system, is paramount in developing a more comprehensive performance profile of what works to inform a more joined-up, holistic and effective system of support.

Objective 4.2 Embedded evaluation and feedback

yourtown agrees that services providers should be required and resourced to build evaluation into their program. We also welcome that the Commission acknowledges that a key challenge for organisations in evaluation is resourcing given it significant time and is an additional consideration for staff to incorporate into their frontline roles when delivering services that are already stretched and in high demand. The Commission must ensure that funding/contractual arrangements recognise and support evaluation activities through providing appropriate funding and capacity building support. The latter will be particularly important to schools and smaller programs and organisations, which will start from a low base in this skillset.

We agree that communicating evaluation results openly is important, and would like to see this explicitly include the need to share detailed findings, for example, about how and why a program is (in)effective, the components of the program that are (non) important or (un) essential, the barriers and facilitators to engaging the evaluation population so these results can be used to improve other child and family programs.

Objective 4.3 High quality research

We have long campaigned for, and therefore welcome, Action A making 'research into child mental health needs and treatment a priority' and agree funding must match that of funding for child physical health.

In relation to some of the research priorities we have identified in our work with this cohort, we would prioritise boys and help-seeking given that they are significantly less likely to seek help (for example, 75% of all contacts from under 12s to Kids Helpline in 2020 were from females 23% were from males, and 2% were from intersex/trans or gender-diverse), yet as evidenced by the higher suicide rates amongst this cohort (with more than three quarters of deaths by suicides occurring in males), are clearly in need of support.[32]

We would like to see research into girls and self-harm prioritised given that girls are nearly twice as likely to be hospitalised due to self-harm than boys and that the specific rate for females aged 0-14 of intentional self-harm rose markedly between 2007-8 to 2016-7 from 19 to 317 cases per 100,000.[33]

We would also like to see investment into research investigating the use and innovation of digital mental health supports for children and young people. Online services are and will increasingly become a key source of support to which children turn.

Finally, we would ask that all aspects of research – including the development of the research ethics framework - meaningfully include consultation and where appropriate co-design with children and families.

[32] https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm
[33] Ibid