Roundtable Report

A Prevention System for Child Mental Health and Wellbeing in Victoria

Melbourne, Friday 12th May 2023

democracyCo

In this document

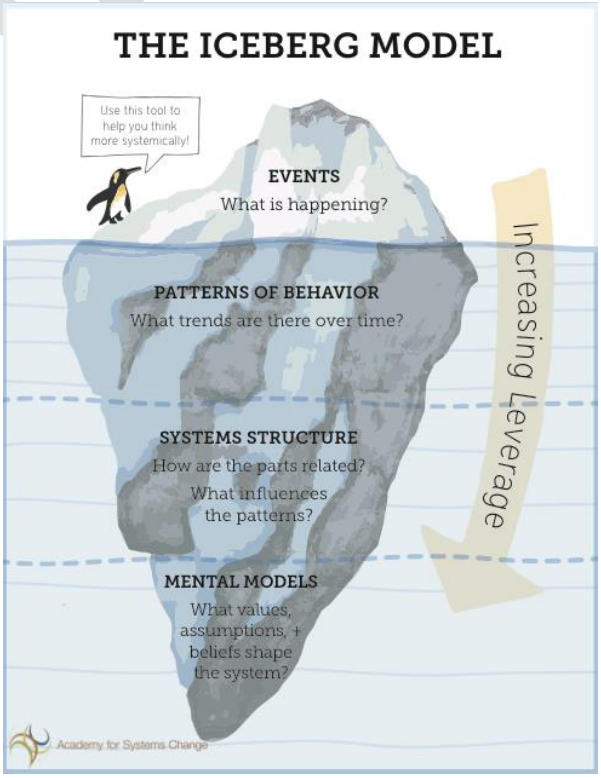
About the Roundtable

Good mental health in childhood provides the foundation for lifelong health and wellbeing. Recognition of the significance of children's mental health and wellbeing such as through the establishment The National Children's Mental Health and Wellbeing Strategy means that it is an important time to anchor prevention into the national and state policy and service landscape.

To date, children's mental health has often been seen through the lens of adolescent and adult mental health with the consequence being a focus on diagnosis and treatment. While this remains important, it's timely to advance an approach that focuses on prevention and early intervention if we are to achieve optimal outcomes for children and families, and subsequently 'stem the tide' of the current growing demand for mental health services.

The Roundtable brought together a diverse range of experts across sectors to focus on action required for progress, both experts by profession, as well as experts by experience. Monica Kelly, State Mental Health and Wellbeing Promotion Advisor and Dr Ruth Vine, Interim CEO National Mental Health Commission both participated in the day – demonstrating the high level commitment to this roundtable.

The Roundtable acknowledged and involved the individual and collective expertise of people with lived and living experiences of mental health challenges and recovery. The importance of listening to and learning from the expertise of people who have experiences of mental health challenges as a child, and those who identify as families, carers, and supporters was reflected in the process and participants of the Roundtable. Their perspectives and experiences provided invaluable insights that are important to ensuring that better policies and practices are co-created to better support children's mental health and wellbeing.



Each participant was key for formulating a series of potential next steps to ensure that prevention remains a core component of future planning and responses to child mental health and wellbeing.

"By working together, we can create a coordinated and collaborative response to promote child and community mental health and wellbeing and prevent mental health challenges." Emily Unity

The Roundtable spent their day with a system view – thinking about the system they want to see. To assist them, facilitators introduced the iceberg model – shown on this page.

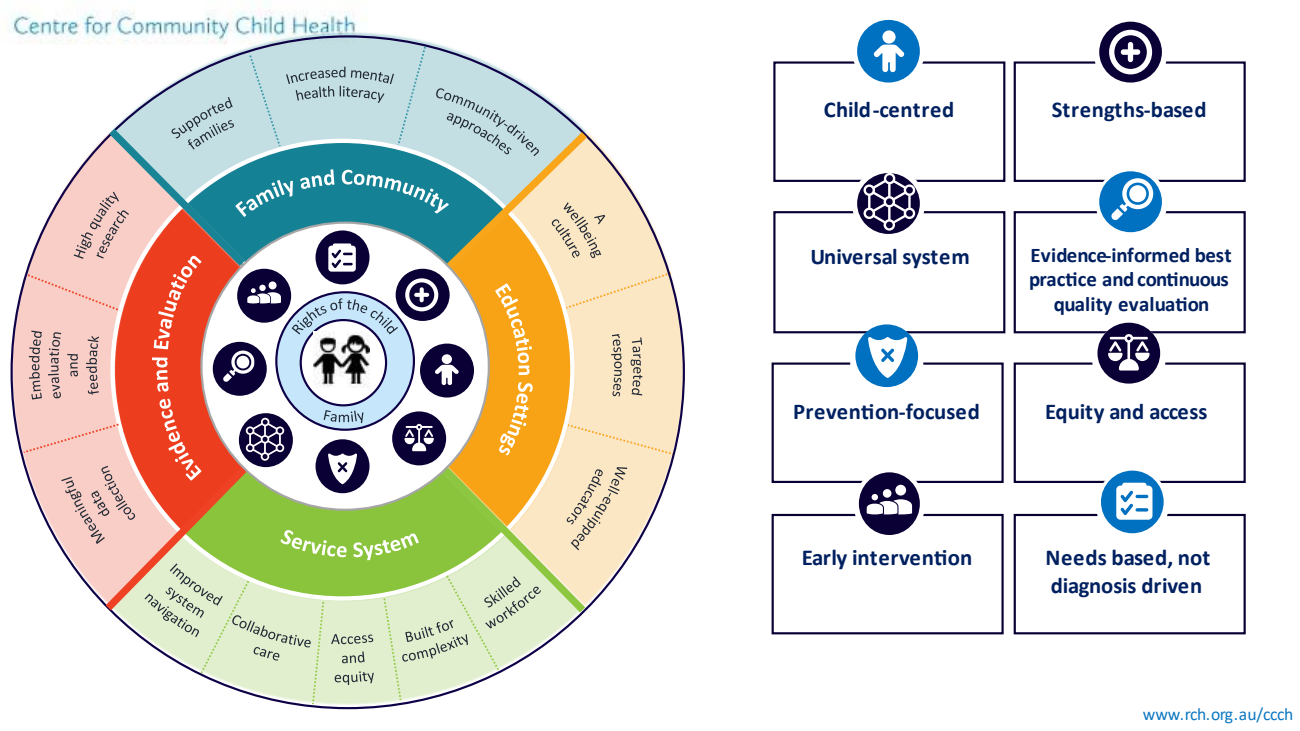
A participant list is provided at Attachment A. The Summit was facilitated by democracyCo.

About this report

This report has been prepared by democracyCo using the outcomes and notes taken by participants.

In the following pages, each recommendation is documented as developed by the participants. In some cases this work takes a narrative form, in others it takes a dot point form - democracyCo deemed that it was more transparent to present the work as it was prepared, rather than take licence to change the format of participants words.

Participants worked on a series of 6 core recommendations – using the framework from The National Childrens Mental Health and Wellbeing Strategy below.



It is noted that the workshop participants did not have the opportunity to seek alignment between these recommendations. It is also noted that some recommendations may be in direct conflict with others. The recommendations in this report would benefit from a process to look across them, to resolve any conflicts and/or thread together aligning ideas.

Our Outcomes

Participants in the roundtable contributed to a session to describe the outcomes from the system they want – which will promote children's wellbeing and prevent them from mental ill health.

Key outcomes which the group agreed to focus on were:

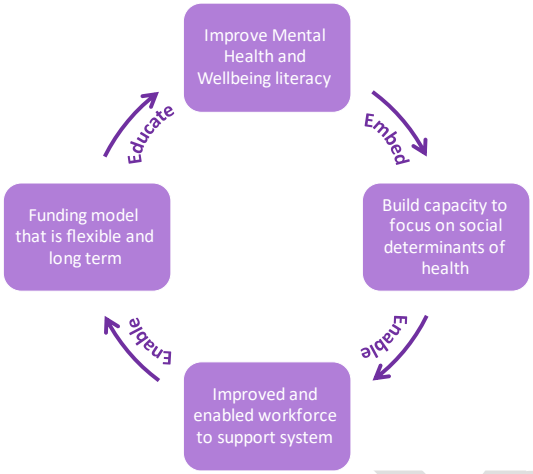
- Help all that know children to understand their lives, see them and help them if help is needed.
- A commitment and resources to start early and with a whole of family perspective.
- To recognise every child is supported as an individual to thrive – through an enabled and supportive community – a village.
- More disadvantaged kids remain well and resilient.
- Better understanding of child mental health and wellbeing as an integral part of child development for parents and all service professionals who work with children of all ages.
- See children as part of a family system that needs support and resources – also children as a whole, not the part of interest to a service professional.
- System that is responsive to the needs of children and families.
- Design the system that places the family at the centre of our thinking.
- Consistent standards and expectations across universal systems like childcare, education and health.
- Reduce the incidence and prevalence of childhood mental health conditions like anxiety, depression and conduct disorders.
- All family members feel heard and supported to be healthy and well.

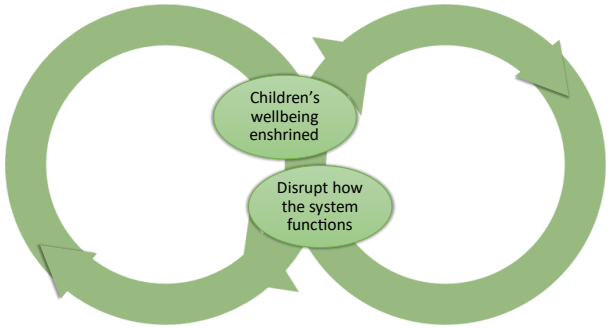
Our desired prevention system

A key outcome of the Roundtable was the work undertaken by a small, diverse sample of participants to summarise and conceptualise their preferred prevention system.
Their reflections on the work were twofold…

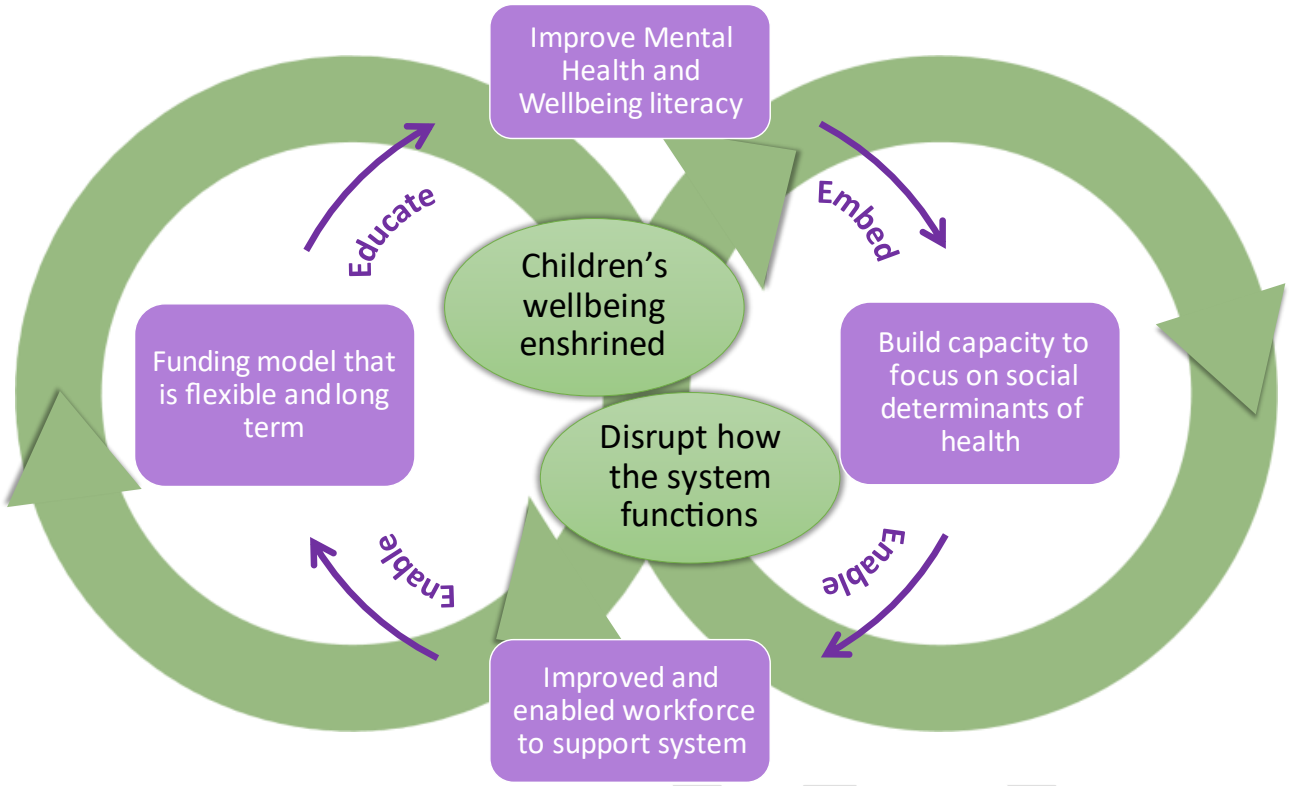
They saw consistency in suggested system improvements sitting across three key areas – educate, embed and enable. A range of core ideas nested within these around funding models, workforce development, building capacity and improving mental health literacy.

In addition to this they observed the need for children's wellbeing to be enshrined in every policy of government, and a need to disrupt the current system – to achieve their vision of the most ideal prevention system.





Bringing these two layers together enabled them to visualise a system that looks like the below:



Recommendations at a glance

There are 6 core recommendations which emerged from the workshop.
They are:

Recommendation 1: A new system / framework that has lived experience and co-design at its core.

Recommendation 2: A flexible, long term funding model which is driven by outcomes.

Recommendation 3: Build capacity to focus on social and commercial determinants of health.

Recommendation 4: Improve mental health and wellbeing literacy.

Recommendation 5: Childrens wellbeing enshrined in every policy and decision we make.

Recommendation 6: Workforce that is skilled in understanding and responding to social determinants of health.

Recommendation 1: A new system / framework that has lived experience and co-design at its core

What we want, and why

We know that the best chance of preventing mental health issues in children is to design a system that is fit for purpose into the future. This is one which is co-designed by people with lived experience, to empower the voice of the child and their families, in determining priorities, ways of working. To do this we need to disrupt the way the current system is organised, overseen, and prioritises workforce over users (people with lived experience).

We need a range of expertise, including lived experience expertise, who have power and influence throughout the co-design process.

When we talk about the system, we mean government, policy and regulation, clinical and community services – and those who bring expertise by experience.

The current system and user experience/journey isn't working. Systems are designed by what we know at a point in time, and around the people who run the system. Co-design will help systems remain relevant to the end user and changing needs of communities.

We rapidly need to move away from a paternalistic view to empowering consumers. People who use the system know what they need and what works for them. People with lived experience should have an equally valid and valuable input into shaping the system as those that bring the evidence base.

We want our system to be accountable, not performative.

How we make this work – what's needed to support it and who needs to be involved

A human cantered design practice (HCDP) playbook already exists and shows what best practice looks like. Our system redesign needs to be done through lived experience led research & fuelled by self-determination.

This will only work is decision makers, funders, providers, consumers all come together – to co-design this. Key parts of this process should include:

- consider the social determinants of health that make and shape mental health and wellbeing (income, housing, education, health, media & industry).
- The Co-designed blueprint / framework / processes that they discuss needs to be accessible - designed for accessible participation.
- Enabled through funding system and governance.
- Transparency and accountability; commitment to listen, respond and acquit actions with those with lived experience.
- Wellbeing impact assessment in all policy.

- Share power and decision making; meaningful and genuine co-design.
- Build expertise and capability; skills in asking the right questions.
- Reimagine methodologies and interfaces that are accessible and will successfully engage child voice. Target tools for audience.
- Contributions should be appropriately remunerated. Lived experience contributors should be supported to actively engage.
- Upskill in systems thinking capability.

Mindsets needed to make this work include an openness to learn from others, consider diverse perspectives, unlearn, a shift of values and beliefs, a willingness to change, recognition that the process takes time and that there may be mistakes along the process and most importantly to sit with and follow through the discomfort.

Tension / challenges we might face

A new framework for how we ensure mental health and wellbeing for our children will encounter some challenges. We expect to see challenges in the form of

- Pull back to status quo, revert to old ways of working.
- Risk of overburdening people with lived experience.
- Ensuring the health wellbeing and capabilities of lived experience workers through health and safety initiatives and monitoring.

Our first best steps

Design of the new framework should be led by lived experience.
We recommend that a working group is formed to lead this work – and overtime is enabled to build its capacity to transfer their role to a regulatory position.
This group should:

- Apply what is best working/evidence practice in a practical and tangible way;
- Working group to assist with devising frameworks/blueprints;
- Keep focusing on what is working and not working;
- Evaluation process of working groups and frameworks;
- Advocacy

Resources and time need to be given to this process, as do decision makers given time to process the changes in how we view our system. Governance and project systems to have adequate time and extension.

Recommendation 2: A flexible, long term funding model which is driven by outcomes

What we want, and why

Prevention is a long-term commitment, therefore funding for policies, programs and services need to be long-term – and focussed on long term outcomes.

We know that addressing social determinants of health (SDoH) improves outcomes; therefore, if we open up the funding so it can be spent on any aspect of the social determinants of health, we will improve outcomes for families and children.

Changing funding models improves efficiency, quality of services provided, and addresses the social determinants of health and helps to improve child and family mental health and wellbeing.

We recommend a change to the funding model which would include:
Evidence based outcome measures that sit around the social determinants of health
Support the circle that supports children (family, environment)
Driven by families informing what their needs are, rather than prescriptive guidelines on how to use funding
Flexible, long-term models which include CPI, and acquittals at the end of the grant period rather than at intervals throughout.
Block funding.

"We don't necessarily need more money; we just need permission to be able to use the money differently and more efficiently."

How we make this work – what's needed to support it and who needs to be involved

We need a shared understanding of how to design a system which reflects the social determinants of health. Any organisation or governmental department providing services, programs and policies addressing the social determinants of health should be involved in this work, including philanthropists and people with lived experience.

Ideally, we would like to see inclusion of funding in grants for the backbone of an organisation, that drives change in the program (i.e., overhead). Partnerships: connecting those who are looking to build community and those who are looking to build up their own organisation, and a model which supports incentivisation to work together and not compete for the same pool of funding.

Funders (i.e. government) need to shift from 'we know best' to 'families know best'.

To make this work we will need collaboration with each other to advocate to state and federal Government, leveraging existing services and providers and investing in existing community services rather than creating new organisations and programs (especially in rural/remote areas).

We may also need to see an uptick in advocacy to state and federal Government with sharing lived experience.

We will need a focus on evidence and evaluations - on which programs work, and programs that don't work so that we don't continue doing work for the sake of keeping our funding.

Tension / challenges we might face

New and changed funding models will be challenging for many – individuals, communities, schools, Federal and State Government and also within sectors and organisations. But as we shift to this new model, we should not lose sight of why we are doing this – to improve outcomes. To support change we should boost existing partnerships between health and social care, justice, etc. and support / shine a light on organisations who are already doing collaboration well.

Our first best steps

This recommendation requires leadership at Federal, state and local government levels in partnership with community, with an influential member of the Federal parliament to spearhead it.

Specifically we should pursue:

- Community - Advises stakeholders and Government on what the community needs are.
- Stakeholders - advocate to all levels of Government to create funding policies with an overarching commitment to health and wellbeing.
- Local Government - Liaise with community to provide information on what community needs are.
- Federal Government - someone at the Federal level to drive the change to funding. Bipartisan approach that policies for children and wellbeing should apply with changes to Government.
- Victorian Government - incentivising organisations to work together.

Recommendation 3: Build capacity to focus on social and commercial determinants of health

What we want, and why

We know that Mental Health and Wellbeing is largely influenced by the social determinants of health – where we are born, live, play and grow up. Having our basic needs met are the foundations of Mental Health – obviously this starts in childhood. Until we can focus at every level on mental health & wellbeing, a prevention system will not be a reality.

We need to achieve outcomes at different levels, but first we need to identify where we need to build capacity – and it is not just with practitioners. Each element provides an opportunity to build good mental wellbeing.

We want everyone in service system, community system and policy system to be asking about things like basic needs, and measure these – so we can better respond / prevent through a SDoH lens (this recommendation links to the recommendation we made on wellbeing in all polices of government) – and we need to build capacity for them to do this.

We know that many people in our community have adverse childhood experiences which are detrimental to their mental health and wellbeing – the facts are solid, the evidence is in. We don't need more evidence, we need to act on it!

Regardless of the part of the system we are in, we also need to remember we are working to mutually reinforcing outcomes - health, alcohol and other drug prevention, etc. It's not just about prevention of mental ill health – we are looking for improvements in all these things will lead to greater wellbeing alongside productivity and GDP.

Ultimately, we want to see more money to support social determinants and more legislation/regulation to keep commercial determinants focussed on wellbeing.

How we make this work – what's needed to support it and who needs to be involved

A collaborative effort is required to make this work.

We need all tiers of governments to align, need tripartisan support (ideally). To build tripartisan support, we need to get community on board. Need to build consensus about what we require from government.
This could be led by a central government agency - (Department of Treasury and Finance/Department of Premier and Cabinet DPC)?

This roundtable could lead on this to work with government and build citizen engagement – it needs champions, some resources, good implementation science & may require legislation.

In addition to this we want to create a citizen movement - for our children, an authorising environment - charter (eg. of human rights) – we need to push to something that prevents governments from coming in and changing. We want community and stakeholders get on board to one coalescing idea - that is children (yes mental health of children, but also for our children's future).

We think it also might be valuable to explore ways to incentivise prevention. Perhaps supported by a child outcomes guarantee - to hold all governments to account. Eg. European Union child guarantee. Fund the champions and a bit of the 'glue' (eg. reward services for asking about SDoH), connect the bigger social policies. Practice change for services to ask about peoples basic needs.

We have services and some elements of systems- but we are not working together to enable capability to look at these resources in a SDoH lens - $6B in Mental Health funding, billions in housing etc.

Others who could support are Centre for Community Child Health, Commissioner for Children / Young People, Premier, DPC, Prime Minister and Cabinet (pros and cons) - or perhaps in future, build to this. Or need some oversight body to hold government to account.

Tension / challenges we might face

Illness has a face - prevention doesn't have a face, by definition it is lack of problem.
We are not one community - we are many communities.

Tension in expecting government to provide data but there is inherent challenge - as they don't like to publish it. Need to consider philanthropy as the people to support the citizen engagement aspects - and data/reporting to encourage government (as they can be reluctant to publish info that highlights the problem / government failing).

Our first best steps

Support existing leadership to come together – (e.g. ACOSS / VCOSS) - with Government. Some ideas for what they should consider include:

- Start somewhere? First 1000 days (at multiple levels) -
- Build campaigns for children
- Social determinants cluster
- Get cross sector to come together more.
- Office for children / Minister - concept of Wales Commissioner for future generations, but not same.

1. Child Impact statement - Future statement, Bring in Commissioner for children and young people - Written by children.
2. Consider local governments leading the way on that (undervalued player in mental Health).
3. Leverage local government to lead the way in colocation of services with community spaces and with open spaces/liveable.

Key players include Philanthropists, Commissioners for children and young people, VHREOC, Future industries.

Recommendation 4: Improve mental health and wellbeing literacy.

What we want, and why

The group debated whether this was a development task, to establish it at all, but we all agreed it should be improved. Having a clear understanding of what mental health and wellbeing literacy IS, is a core task, for clarity.

We feel this should occur in all children, for all age groups of children, however we identified two groups: in children and families in community, and in service providers.

This needs to be done to improve protective factors and their uptake, to enable identification of mental health issues and low mental wellbeing states, for example to identify emotions, environmental and other factors and to promote agency for people and to establish it. A common language could be beneficial and could be explored, and a sense of the value of this.

Outcomes intended include increased personal and family resilience and capacity to protect oneself and prevent mental health issues, measurable increase in ability to seek help, establish mental health as a kind of regular and accepted maintenance task (like dental health!). Fuller lives are lived, reduced stigma (including self-stigma), connections are increased, emotional regulation is addressed, rates of mental illness are genuinely lower, lifestyle factors like physical activity, better sleep and health childhood nutrition are increased (as these are linked to improved mental health). Literacy encompasses understanding, language, ability to express, and a shared literacy improves. We are practical about mental health literacy.

This work should be supported by incorporating the Mental Health and Wellbeing Continuum.

Functional mental health literacy is needed - so a person is supported to do something / take action.

How we make this work – what's needed to support it and who needs to be involved

Everybody of course is required to bring this to life; however, the following are critical:

- allied health,
- early childhood services and schools,
- community cultural leaders,
- local governments,
- maternal and child health services,
- NGOs with skills and access,
- Cross government departments with levers.

Beyond Blue, MCRI, knowledge institutes could be the public-facing peak organisations to drive the technical / expert and other aspects. Specialist mental health practitioners need to have this common language - including psychiatrists.

Children will need to participate and buy-in, and most discussion agreed the health sector, and then second was the education sector, and federally funded initiatives.

Must be community-led, place-based/local, through a cultural lens. This means community-based settings (libraries, sports settings). Active campaigns as to what mental health literacy is and its benefits are needed to counter commercial social marketing influences. Agencies, partners and actors must influence media coverage and mass communication in a positive way. Digital tools for mental health literacy to reach children and young people. Stuff that leads to family dinner table conversations is likely to be hitting the mark. Ambassadors was debated and not agreed universally by the group.

Overall, we need to move away from short programmes, to embedded teaching/training in school (a curriculum) approach. Presenting this material well in an engaged way is ideal or even necessary, with fun and humour to make it accessible and engaging.

Need to deliver interventions aimed for children at the level of, accessible to, attractive to, and in the language of, children and young people.

We see partners: talking about mental health literacy constantly, speaking the same language (e.g. people talking about which colour you are). Community and stakeholders are sharing the same language (common understanding, not linguistic language), there is cultural adaptation of critical resources. There are resources to have a workforce to train professionals in mental health literacy - this is going to capacity building, beyond awareness-building.

Care givers have a crucial role, who are provided tailored help to know how to build mental health literacy - and have it themselves. Another setting should be early childhood centres. Emphasising what actions arising from emotions counts and no feelings are right or wrong.

Tension / challenges we might face

It could become too serious and not accessible or attractive - a bit gloomy! Needs to be fun and positive and empowering. We are wanting the messages to be everywhere without unlimited resources, so focusing training and areas of focus is necessary. A challenge is that in aiming big, we don't achieve a good impact for specific groups, so focus on health equity. Competing (trademarked) models that are all different don't derail the effort - there is synergy and sharing of a fairly common approach.

Another risk is that we raise expectations and don't deliver - e.g., there is no access to some specialist services, and people don't open a conversation because they don't know what to do with what might happen or have a pathway for any mental healthcare identified as needed. Avoid paralysis due to lower resources - increase coordination as a remedy. Could be dismissed as soft and fluffy, watch out for that. Commercial determinants of health are relevant - aspects of this getting commodified was discussed.

An idea that was raised but not universally agreed was the idea of a watchdog that looks at language used and can call out hysterical or alarmist language, in some circumstances. Effectiveness of this concept is unclear.

Resources we have / resources we need

Specifically: there is a key framework in early years and the school curriculum which do address mental health literacy. The national strategy, Emerging Minds (national programme), Mental Health in Schools. Consider how it is delivered - quality and form - reflect on what it is delivered alongside. Resilience, Rights and Respectful Relationships programme in Victorian schools. Aware Respectful Relationships is opt-in, regional Victoria may have more gaps. But we have programmes, national programmes like Beyond Blue, Cathy Freeman's organisation is an excellent channel/voice box to community. Doctors Principals Network (MIPS) is an example programme for health professionals. Student Representative Councils or Teams are known to tackle. Any Australian Psychological Society and the MCRI coordinators in every school are effective (except high fee-paying independent schools).

Resources/training and design is going to teachers. Child-targeted capacity and training is needed, and a little more in primary care, plus paid time to take up that training once developed. A focus on mental health literacy in every school website / online resources. Consider any requirement for standards (or regulation or coordinated menu of language or approach in order to improve the quality of resources). We remember a menu of programmes (BeYou). Make sure we engage and reach child protection and particularly disadvantaged populations.

Our first best steps

Beyond Blue is a possible leader of this initiative, and MCRI could be a key leading partner bringing rigour. Whichever body leads the collaborative, needs authorised to bring in a new form of language that is adopted. The group feels one partner or leader is not achievable - needs to be a Mental Health Literacy Collaborative.

Young people to spearhead messaging and media campaigns and visuals - the face, drive campaign through youth and young people, who take up and early adopt well. Experienced advocates young people identify with stand alongside / are there.

Start with the shared language and concepts so people and partners are all talking about the same thing in this work - resonating across professions and partners and stages and cultures. Not all understandings will be the same, but the effort is critical.

Apply the interventions with very young children first - start early - get in early (no right and wrong emotions etc., normalising talking about mental health, de-stigmatizing conversations about mental health, improving literacy).

Continue national adaptation - adopt national materials.

Co-design with young people.

Recommendation 5: Childrens wellbeing enshrined in every policy and decision we make.

What we want, and why

We want to see every policy made, and every decision made, by Governments around Australia to have children's wellbeing enshrined in them.

Children have a basic right for society to take care of them – and their lives and wellbeing should be at the centre of everything we do.

We know we have declining mental health – which is being demonstrated by children in their lived and living experiences. We also know there is a lack of support and certainty of services.

We are dealing with complex bureaucratic system, where we see varying levels and in some places lack of accountability.

Childrens wellbeing is in our organisations but doesn't survive through systems of governments (i.e., NDIS, child safety framework).

Children are the only future we have – and it is incumbent on us and all our futures to ensure that their mental health and wellbeing is central to everything we do.

We know that people, across the board feel like they aren't represented in any policies of government – cultural groups, vulnerable groups and minority groups – we know they can't access the system to have their voice heard and their needs met. We see consistent narratives of tokenistic consultation and a lack of meaningful engagement opportunities.

The research and evidence are also showing the challenges we are facing regarding the social determinants of health, the long-term impacts of mental health and wellbeing in children are becoming clear. We see government saving money for later for crisis supports, information about the interconnectedness of systems and their failings, and intersections of systems of oppression.

We also know there is currently a lack of representation in government - median age in government is 50, youth ministers tend to be a cisgender old white man, and early childhood minister only exists at some state levels.

How we make this work – what's needed to support it and who needs to be involved

Collective responsibility is needed between federal government, dedicated child minister, state government, local government, community responsibility, people with lived and living experiences, cultural shift away from only select few being decision makers.

We need to see shifts in:

- change the culture of engagement - make people feel comfortable to get involved in this space, starting engagement with families and children from a young age, including families, carers, and supports in decision making, letting children identify who they want to be included as a support
- change in where and how co-design is being done - engagement types need to be better understood, more co-design work needs to be done for policy and processes in government
- change in communication of children's mental health and wellbeing - culture of creating children friendly language, understanding and defining trust and safety with children and their supports, ensuring children speak for themselves, avoiding reframing what children's voice and perspectives are.
- "a different muscle needs to be developed" - retrain the adults, every worker that engages with a child needs to have understood infant and child mental health / trained, creating a new culture
- training for children's mental health first aid - delivered to parents, teachers, everyone who engages with children, co-designed and co-produced.
- training for how to engage with children - how to communicate, how to make it meaningful how to listen, hear, and interpret, setting-specific training.
- children's mental health literacy support for - families and supports, services (not just health), decision makers.
- declinicalising, more holistic wellbeing - not sticking to rigid models of wellbeing, moving away from diagnostic models.
- power imbalances need to be given up - adults need to step back and amplify children's voices.
- looking at everything through a children-specific lens - reframing systems thinking to see how they affect children, re-evaluating policies and processes, shifting away from imposing an adult understanding of mental health and wellbeing.
- defining children's wellbeing with children themselves - challenging adult understandings, re-creating understandings alongside children, focus on connection and values.
- building connections between people - children and parents, children and teachers, children and service providers, children and governments

The things we need to see being done to support this recommendation include:

- create safe spaces for kids to have a voice
- child safe standards
    - only exists for organisations that specifically work with children
    - putting in policies and frameworks in place
- child's rights framework
    - goes across sectors and spaces
- going beyond policies
    - implementation guide
    - outcomes and accountability
    - transparency about how frameworks are implemented
- evaluating all policies with a children's lens
    - understanding that all policies can affect children
    - not siloing off children's policies

    - a culture of centring children's wellbeing and collective responsibility
- learning from and with people who are leading children's engagements and rights
- proactively challenging assumptions about mental health and wellbeing
    - e.g. if a child is exposed to something, parents/supports can help to educate the child about it
    - e.g., self-harm scars
    - e.g., mobility aids

Tension / challenges we might face

There are barriers and challenges that we see impacting on this idea:

- barrier between kids and adults
    - power imbalances
- lack of use of feedback and engagement opportunities
    - culture of only providing feedback when it's really good or really bad
- risk of blaming supports for challenges that a child is experiencing
    - e.g. parents/supports
    - lack of support for supports
    - lack of empathy
- listening barriers
    - not enough skills to listen effectively and meaningfully to communicate children's perspectives
- rigidity of "mental health" and not wellbeing
- policies not thinking specifically about children
    - not enough specific work about younger ages
    - e.g. jobseeker
- systemic inequalities and intersectionalities
    - lack of understandings how policies and decisions overlap
    - e.g. getting rid of parks
    - e.g. cost of living
    - e.g. housing
    - affects safety, community safety, and wellbeing of children\
- binary perspectives of potential opportunities, activities, and resources
    - e.g. demonisation of technology
- lack of dignity of risk
    - focus on duty of care
    - parents not being comfortable with teaching them about certain topics
    - parents not being comfortable with teachers teaching them about certain topics
- lack of understand of culture and how that intersects with the role of a child
    - only western understandings
    - individualist vs collectivist
    - lack of allowing understandings
    - lack of policies that take intersectionality and diversity of children into account
    - monocultural policies, frameworks
- bias or lack of diverse information
    - leads to assumptions

    - e.g. waitlists information the media discourage people to access services
    - lack of information about diverse understandings of mental health and wellbeing for different children
    - lack of opportunities to ask children about their perspectives
    - more assumptions about what is “right” and “wrong”
- lack of understandings and supports that are made for and by diverse families
    - e.g. nuclear families
    - e.g. foster system children
    - e.g. cishet parents
    - lack of engagement with families that need to be prioritised
- lack of usable information in school curriculum
    - e.g. how to do taxes
    - e.g. how to navigate mental health challenges
    - e.g. how to handle family and domestic violence
- lack of trust in capacity and capability of children
    - thinking children cannot “handle” certain topics when they are younger
    - e.g. mental health
    - e.g. family violence
    - e.g. sexuality and gender

Resources we have

- technology
    - leveraging digital systems
- allowing open communication and anonymous communication/feedback
    - suggestion boxes
    - culture and support to utilise feedback systems
- elders in communities
    - leveraging cultural knowledge
    - historical learnings
    - trauma-informed
- support for parents/supports/carers
    - improving understandings of and equality with maternity vs paternity leave
    - training and resources distributed to parents/carers
- learning from international and interstate leaders
    - e.g., Sweden’s maternity and paternity leave supports
    - participatory children’s researchers
    - methods from children’s play engagement
- adult mental health services
    - addressing parents mental health proactively
    - upskilling parents beforehand
    - awareness of supports available for both parents and children
- family violence supports
    - leveraging existing supports and education systems

    - supporting parents and children in an empathetic experience
    - informed by existing research and lived experiences
    - e.g. intergenerational trauma
- existing training programs for students and parents/families/carers
    - e.g. respectful relationships
- current movement towards community engagement and youth involvement
    - change in stigma and bias towards engaging with younger people
    - more curious population
- harnessing the knowledge of non-traditional supports
    - e.g., community-based supports
    - upskilling groups to share their expertise
    - increasing awareness of opportunities and accessibility of opportunities
- improving the foster care system
    - better understandings of common themes of wellbeing experienced by children in the foster carer system
    - supporting the supports
    - improving referral pathways
    - resourcing and funding
    - providing better connection to supports and opportunities

Resources we need

- streamlined training to better engage with children
    - some sectors do it well, some not
    - developing training that allows for upskilling of how to best engage and communicate with children
- new spaces for children to feel safe
    - created by and for children
- a collective hub of resources
    - information transparency
    - accessible by different types of supports (e.g. teachers, parents, siblings, decision-makers)
- resources to support collaboration and communication across services and communities that support young people
    - providing spaces that are facilitated and created for meaningful collaboration
    - ensuring that community members participate meaningfully
    - creating space to share knowledge and understand what is and is not happening
- education in schools about mental health challenges and factors that contribute
    - e.g. family violence
    - increased awareness and understanding of supports
    - understanding what safety feels like
    - what a safe and healthy family environment looks like
- new governance structures
    - ensuring that new power can come forward

- considering decision-making structures that don't involve traditional western groups e.g. boards, managers

Our first best steps

- children's rights frameworks
  - establishing a framework of centring children's rights
  - ensuring that it does not inhibit what we're trying to achieve
  - developing further policies and processes that allow for specific settings and localisations
  - ensuring a children's lens focus across other areas of government
  - developed with children through co-design and co-production
  - taking an intersectoral and multidiscipline approach
  - co-creating meanings of safety and wellbeing with children
  - adapting frameworks and making recommendations for specific sectors and localities
- implementation plans
  - ensuring accountability to children's rights
  - localising and specifying values and ideas to ensure that they have tangible outcomes
  - ensuring measurement of outcomes
  - evaluating with community and children
- top-down change
  - establishment of federal, state, local, and community leadership
  - ensuring the right people are children with the right expertise
  - creating cultures of engagement and focusing on children by role-modelling
- bottom up change
  - allowing for open communication and feedback
  - leveraging technology and community networks
  - talking with children and families to ensure that there is going voice being heard
  - creating and amplifying opportunities for engagement and civic participation
  - creating cultures of engagement and participating
  - culture of continuous improvement
- support for collaborating across sectors and disciplines
  - learning from and with each other
  - leveraging existing work and expertise (e.g. education x health x justice x policy)
  - understanding intersectional experiences of mental health challenges (e.g. culture x LGBTQIA+ x disability)
  - working with existing systems and services (e.g. foster care, antenatal, community systems)
- support for parents/carers/supporters
  - antenatal and infant mental health
    - not practising in a medical model
    - ensuring that it does not impact the mother/child relationship
    - low risk: midwives
    - high risk: obs
    - introducing systems that support women to birth safely, not medically
  - need to enshrine children's wellbeing from infancy

        - requires engagement with parents
        - proactive education about the impact of a child (before the birth)
        - ensuring that there isn't a reliance on a singular parent
        - challenging stigma about who is the main caregiver
        - inclusive of non-traditional family structures regardless of gender or relationship to child
        - wellbeing support for parents/carer/supporters before a child is born
        - improving maternity and paternity leave
    - schools and education systems
        - co-creating communities and spaces with children
        - supporting and educating the educators
            - ensuring that teachers are not the sole person responsible for children's wellbeing
            - allows teachers to just teach
            - providing more supports in the school that can support the other factors
            - providing parent/carer specific supports within schools
        - peer supervision / reflective practice / community of practice for teachers in early childhood settings
        - more opportunities to engage with supports and families in a proactive way
        - education in emotional literacy and acknowledging what core emotions are and what behaviours may be attached
    - community level education and training (see above)

community culture shift (see above)

Recommendation 6: Workforce that is skilled in understanding and responding to social determinants of health

What we want, and why

We recommend that we build / rebuild a workforce that is skilled in understanding child mental health social determinants and how to respond - ensure a workforce that is family facing. Universal platforms such as community health, education and social care are well placed to respond to children health and wellbeing and child mental health and wellbeing.

We want to grow the passion for working in child health (and child mental health) enabling the light bulb to go off – to enable better holistic support for children's wellbeing. We want funding models that allow for funded and protected time for collaboration and practice improvement, supported practice models, and reach out to regional and rural areas. Multi-disciplinary team (MDT) models beyond health, culture and values, each discipline acknowledging the culture and value, speciality and knowledge each other brings, shared language and shared understanding relating to child mental health and wellbeing. This takes time to nurture, and it requires connections with each other to do this.

Who decides what the workforce does and what? and how they do it?

Decisions are being made by people who are not on the ground, keeping a broader perspective for what you want to achieve for child mental health and wellbeing and share that but also respecting disciplines and what each brings to this end goal.

No matter the discipline, we want to ensure the workforce knows how to move from being a support practitioner to transition between disciplines to support a child.

This will take - using existing infrastructure to increase access to workforce, flexible access to other professionals (e.g. social care, etc), using workforce better (e.g. 5 min co-consult with child and family), One-stop shops and co-location (physical and virtual), resourcing the glue that enables workforces to collaborate around child mental health and wellbeing, support along the continuum (i.e. ANU combing psychology and medicine in undergrad as a degree).

How we make this work – what's needed to support it and who needs to be involved

We've seen it done well in some places and not in others relating to undergraduate curriculum in education. There is work to be done that captures the desire of aspiring practitioners to want to pursue a career in child health and wellbeing. This requires both improved integration of child health and wellbeing into the undergraduate curriculum, but also the timing of exposure to this content and role models early in undergraduate training e.g., medical practitioners, allied health, nursing to want to work in child health. Changing the way different positions work with each other is also needed – having connections built in across settings and sectors e.g., education and

health (schools and hubs) e.g., Living Free community agency, drug and alcohol, justice in place in Frankston with flexible funding and funded by philanthropy.

This would require different thinking relating to resourcing (such as block funding and/or philanthropic partnerships) and service models as examples, to enable workforce to meet the needs of children, families and communities.

We need to build a workforce that listens (to the needs of the people it's working for) and is flexible. No single facility should ever be built as a single facility again - should be multidisciplinary. Schools as community places - why aren't we using those for places for children and young people and families can congregate and access services and wellbeing opportunities.

Some other things we need to address / improve include:

- We need to overcome insurance barriers that prevent people and services in delivering flexible spaces, programs.
- Case managers and navigators and connections with parents/carers and families and connection to case worker if they stressed and need help
- ECEC workforce ratios at 3 years of age 1:11 - is this undermining health and wellbeing of children in ECEC with those ratios - impact that has on workforce to provide high-quality and nurturing care, play-based learning implementation, being able to respond to emotional needs of children (its cyclical) prevention in the area of ECEC workforce
    - Do we collect data on what we know are precursors to child difficulties e.g., what happening in ECEC (quantity and quality - workforce) training of ECEC workforce and upskill existing ECEC - a provider that parents and child see more than anything else but starting from low base and payment of ECEC
- Funding the enables multi-disciplinary teams (MDTs) in place across health, MCH, Specialist, education, ECEC that can respond to adversity and connect, and that workforce is trained and supported to respond.
- Helpdesk for GPs/community paediatricians staffed by child psychiatrist for secondary consults -enabling a skilled primary care workforce.
- Getting clinicians such as psychiatrists or others excited about capacity and capability building as part of a MDT service response, not just provide 1-1 care.
- School-based MDT with health and teachers supported, enabled community capacity building and Communities of Practice
- Workforce burnout
- Levers such as key performance indicators (KPIs) at service and government levels that are outcomes-based and attuned to the SDoH. These would need monitoring capabilities built into to assess progress. Workforce response based on achieving these outcomes.
- Including SDoH outcomes in accreditation standards
- Explore leadership and governance mechanisms including resources to Australian Children's Commission to drive such initiatives and a Minister for Children and Office for Children in PMs Office (survives changes in government), bilateral agreements with States/Territories and Australian Government to deliver a prevention workforce, cross-departmental budget bids to enable workforce development and growth.
- Building the workforce capacity for family partnership and relational practice

- Resourcing the glue that enables workforce to connect and respond, such as workforce networks that professionals can call on for advice in supporting families and dedicated time to connect across disciplines.
- The tertiary care placing downward pressure on the primary and secondary care.
- Disciplines such as Infant Maternal and Child Health Nurses (M&CH) establishing opportunities for reflective practice with supervision and/or communities of practice.
- Unified and extensive stakeholder engagement and action to build a workforce responsive to SDoH including universities, state/fed governments across departments, colleges, unions, local government, professional peaks, community organisations, community stakeholders, children and families, philanthropy, peers.

Irrespective of discipline our workforce should be able to talk about what families need (respond to adversity) and respond accordingly by bringing in other services. This is about people working differently - Communities of Practice, give teacher time and space to peer support, reducing professional isolation and making connections and solutions and having specialist professional as the backup. Raises the scope of practice of the workforce - building confidence and competence, below the line connections.

Work in this area is about creating a shared vision and you as a professional can see yourself in it and feel enabled to keep child and family central. To achieve this there needs to be a voice and evidence to demand this change, to create a movement to compel change, levers such as incentivising and KPIs to realise change, collaboration across sectors and disciplines and translations to scale.

Tension / challenges we might face

We know we are not dealing with just one workforce and we need to support people in place to step up and respond. We need to consider numbers of people in the workforce, curriculum, those practicing needs skilling up. We need to remove structural and financial barriers that enable best-practice and support a diverse workforce to include professionals like peer support workers, mental health coaches, looking at new roles. Structural barriers removed that enables practitioners to see children with developmental concerns, MDTs, wait list issues to see children, one stop shop - salaried team, bul-billing team.

Some other challenges this faces are:

- Cycles of government, ministers, bureaucrats
- On the ground - delivery of service and time to deliver the service (e.g.,' you went to something last week")
- Tension between direct and indirect service delivery and continuing quality improvement
- Keeping out of the Herald Sun headline
- Training comes in a lot of forms - enabling this to happen
- Some people thinking we know it all and don't need any other training.

Resources we have

Good examples: MARRAM tool and training alongside the tool e.g. enabling tool that facilitates response, different workforce levels know how to respond - its legislated.

Other examples include:

- Mertil - Deakin University - relational practice
- Family Partnership models
- Be You
- Relational practice training and models
- Commitment about the importance of this, leadership, someone to drive it, champion (Premier, Minister, etc)
- COMPASS - Community of Practice with child psychiatry, paediatrician, primary care GPs, nursing. Demonstrated less burnout, connection, GPs can hold children and families while waiting for secondary care, confidence and competency, digital platforms, using multiple funding streams.
- By 5 - M&CH CoP and co-consult with paediatrician using zoom, including capacity building and co-consults with families, confidence of local people grown, learning through doing.

Resources we need

- Lived experience
- Child and family voice in what they want a workforce to do.
- Protected time for training
- Permission from the top to give permission to middle management to enable training and the policies, protocols, evaluation to enable

Our first best steps

- Mapping the current child mental health and wellbeing prevention workforce to understand the existing workforce (e.g., kindergarten teachers, M&CH nurses, etc)

- Aligning a workforce response to a child mental health and wellbeing prevention system and the outcomes it wants to achieve – theory of change.
- Understanding and mapping current models of care that enable a SDoH response to child mental health and wellbeing.
- Determining the workforce needs to deliver a model of care and from here build a workforce capability framework.
- Workforce training needs assessment to respond to SDoH.
- Working with Australian government, universities, colleges and other key stakeholders to:
    - Strengthen child mental health and wellbeing, biopsychosocial responses to child mental health and wellbeing and child and family centred practice in curriculum.
    - Enable a future workforce that can respond to child mental health and wellbeing including the SDoH child mental health and wellbeing (this may include reviewing university course fees that can impact a person's decision on what to study and long-term debt repayment).
- Enabling ongoing training and professional development opportunities across career pathways (early, mid, late career) to develop/mentor skills and capability to deliver holistic, child and family centred practice – better integrating this into usual practice and ongoing reflection of understanding diversity of families.
- Resourcing and delivering models of care that enables a workforce to respond to the biopsychosocial needs and SDoH of child mental health and wellbeing. These models of care are not only evidence-based and best-practice, but flexible, inclusive and accessible to children and families.
- Embedding quality improvement cycles to ensure prevention models of care and workforce are responding the needs of children and families. This can include learning from others such as
    - Child & Family Hubs in Wyndham Vale – responding to adversity - learning of barriers, challenges and enablers, what works to enhance MDT care, colocation not resulting in integration, time to enable and nurture this to happen, silos been broken down, decrease burn out, connecting cross-disciplines through a central coordinator/navigator

Attachment A: Participant List

Name	Organisation
Marcia Armstrong	Principal Advisor, Safer Care Victoria
Christian Barkho	Melbourne Children's Campus
Julia Baron	Chief Executive Officer, Victorian Student Representative Council
Roslyn Baxter	Chief Executive Officer, Goodstart Early Learning
Danielle Besen	Murdoch Children's Research Institute Guest
Alison Boylan	Director, Department of Health, Victoria
Stephanie Brown	Professor, Murdoch Children's Research Institute
Stephen Carbone	Executive Officer, Prevention United
James Churilov	Medical Intern
Pauline Cox	Parent Infant Mental Health Practitioner/MCH Nurse, Austin Health
Ine Dambo	Education & Development Service Consultant, Victorian Transcultural Mental Health
Simone Darling	Senior Program Manager, Centre for Community Child Health (MCRI)
Sarah Davies	Strategy Lead, Centre for Community Child Health (MCRI)
Deanna De Cicco	Melbourne Children's Campus
Jag Dhaliwal	Executive Director, North Western Melbourne Primary Health Network
Liss Gabb	Manager, VicHealth
Sienna Gladstone	Victorian Student Representative Council
Sharon Goldfeld	Professor, Director - Centre for Community Child Health (MCRI) Theme Director – Murdoch Children's Research Institute
Ric Haslam	Director, Mental Health, Royal Children's Hospital
Maja Havrilova	Manager, Department of Health, Victoria

Name	Organisation
Simone Heald	Chief Executive Officer, Sunraysia Community Health Service
Ann Hindell	Senior Advisor, Department of Health, Victoria
Harriet Hiscock	Professor, Group Leader and Senior Principal Research Fellow, Centre for Community Child Health (MCRI)
Suzy Honisett	Postdoctoral Research Fellow, Centre for Community Child Health (MCRI)
Belinda Horton	Program Director, Melbourne Children's Campus
Monica Kelly	Executive Director, Department of Health, Victoria
Lachlan Kent	Research Fellow, Centre for Community Child Health (MCRI)
Alex Kisilevich	Eating Disorders Families Australia
Dan Leach-McGill	Early Childhood Australia
Vikki Leone	Manager, Centre for Community Child Health (MCRI)
Michele Lonsdale	Deputy Chief Executive Officer, Centre for Excellence in Child and Family Welfare
Carmen Ludeman	Melbourne Children's Campus
Joanne Martin	Executive Officer, Wimmera Development Association
Derek McCormack	Executive Officer, Raising Children Network
Emily McDonald	Consultant, Relationships Australia
Justin McDonnell	Executive Director, Department of Education & Training, Victoria
Jo McMahon	Lived Experience Manager, Department of Health, Victoria
Bridget Moore	Melbourne Children's Campus
Lyanne Morel	Melbourne Children's Campus

Name	Organisation
Frank Oberklaid	Professor, Group Leader and Senior Principal Research Fellow, Centre for Community Child Health (MCRI)
Jane Poxon	Director, Department of Health, Victoria
Glenn Pringle	General Manager, IPC Health
Jon Quach	Associate Professor, University of Melbourne
Charlene Quinn	Department of Health, Victoria
Adriana Ridzwan	Department of Health, Victoria
Gehan Roberts	Associate Professor, Director, Centre for Community Child Health (RCH)
Finn Romanes	Director, Western Local Public Health Unit
Ella Ryan	Medical intern
Clare Seddon	Senior Manager, Brotherhood of St. Laurence
Cat Sewell	CEO, Polyglot Theatre
Jill Sewell	Paediatrician, Centre for Community Child Health (MCRI)
Sarah Tayton	Be You, Beyond Blue
Claire Tobin	Assistant Executive Director, Department of Education and Training, Victoria
Emily Unity	Lived and Living Experience, Melbourne Children's Campus
Stephanie Veal	Program Lead, Ballarat 4 Kids
Ruth Vine	National Mental Health Commission Department of Health, Commonwealth Government
Rachel Whiffen	Mental Health Advocacy Lead, Centre for Community Child Health (MCRI)
Roz Zalewski	Murdoch Children's Research Institute Guest
Anna Zhang	Melbourne Children's Campus