Keeping child mental health in mind:

A workforce development framework for supporting infants, children and parents

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Acknowledgements

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Foreword

The Hon Greg Hunt MP

Minister for Health

The Australian Government is driving a new era in mental health in Australia. Helping young Australians achieve better mental health is a key priority so they can achieve their goals and dreams now and into the future.

The formation of the Emerging Minds: National Workforce Centre for Child Mental Health is an important part of our reforms to improve the mental health system, and brings visibility to the mental health needs of our youngest Australians. It is heartening to see their innovative, practical resources and tools coming to life.

The Centre is designed to support professionals in the health, social and community sectors to develop the skills to identify, assess and support children at risk of developing mental health difficulties. It represents a move away from multiple programs to a single gateway for professionals and organisations to access training, resources, practice tools, information and more.

The Centre is committed to early intervention and prevention, where infants and children who may be vulnerable to developing mental health difficulties are recognised quickly and professionals feel supported and confident to work together with them and their families.

This approach seeks to address mental health difficulties early to help prevent the future development of mental illness as children journey into adolescence and adulthood.

The Centre also asks professionals, whether they work in the child or adult sector, to consider the impact of parental or adult problems on the social and emotional wellbeing of infants and children and provides tools and resources to support and enrich practice.

We all have a shared responsibility to support positive infant and child mental health. I commend the work of Emerging Minds to you, to support you to make a difference in the lives of infants, children and families across Australia.

October 2019

Philip Robinson PSM

Chair, Emerging Minds

The Emerging Minds: National Workforce Centre for Child Mental Health extends upon the work that has been done over many years to support a greater focus on the mental health needs of Australian infants, children and their families. This document describes our strategy in partnering with families, communities, practitioners and sectors to advance the social and emotional wellbeing of infants and children up to 12 years of age. The importance of a focus on the mental health of infants and children has been reinforced by contemporary research and there has been a gradual recognition that services need to better address mental health in the early years. This focus is particularly relevant given research on the impact of intergenerational vulnerabilities such as poverty, drug and alcohol issues, and domestic and family violence on infants and children.

Emerging Minds is greatly encouraged by the increased focus in recent years on adolescent mental health. And while we recognise that there are many examples of proactive and effective practices in Australia and internationally to support the mental health of infants, there is a need for even more to be done for infants and children. We understand the systemic, organisational and individual challenges faced by families and practitioners, and we will continue working collaboratively to overcome these.

This document provides an overarching description of our strategy in engaging stakeholders to promote effective support and service pathways for infants and children and their families. I commend this document to you and encourage agencies, practitioners and families to make a commitment to collaborating to support the mental health needs of infants and children and their families. We look forward to working with you all to further a commitment to the social and emotional wellbeing of all Australian infants and children.

October 2019

This document has been developed as a description of the Emerging Minds: National Workforce Centre for Child Mental Health (National Workforce Centre) strategies in furthering the identification, assessment and support of children (aged 0–12 years) who may be at risk of or experiencing mental health difficulties. We recognise the valuable contributions of practitioners, organisations and families with lived experience of mental health difficulties in the creation of this document. We look forward to continuing to build rich partnerships to better support infant and child mental health across Australia.

Infant and child mental health

People can be surprised to hear the term 'mental health' used in relation to infants and children. Mental health is something that everyone has, and it exists on a continuum ranging from good mental health, to times when a person is feeling less well, to a variety of mental health difficulties.

Most infants and children experience good mental health if they are living in a context that is responsive to their needs and stimulating to their development. They can cope effectively with the challenges of life, express and regulate a range of emotions, form close and secure relationships, and confidently explore their environment to an extent appropriate to their developmental stage. They will still feel sad, worried, frustrated and angry at times, but such emotions will not lead to ongoing impairments in their ability to cope with day-to-day life. At the other end of the spectrum, some infants and children experience more frequent or intense difficulties with their emotions, thoughts and behaviours that contribute to significant disruptions to their relationships, development, learning and participation.

Children's mental health is shaped by social, biological, economic and environmental factors. Social determinants such as education, social inclusion, housing and income are unequally distributed, meaning that infants and children who experience disadvantage are more likely to be exposed to adverse childhood experiences and to have the poorest mental health outcomes. The National Workforce Centre aims to support a broad spectrum of vulnerable populations who are known to benefit from efforts at prevention and early intervention.

Research shows that intergenerational disadvantage has increased the marginalisation and social isolation faced by many families and is increasing the risk of mental health difficulties for infants and children whose parents are dealing with the effects of disadvantage (Wilkinson & Marmot, 2003). There is widespread acknowledgement of the need for systemic change which emphasises the early identification and prevention of risk factors for infants and children (Moore & McDonald, 2013; Price-Robertson, Smart, & Bromfield, 2010; Furber et al., 2015). The National Workforce Centre supports a focus on the 'social and emotional wellbeing' of infants and children, acknowledging the importance of the environmental and developmental factors which promote healthy development for infants and children (Burton, Pavord, & Williams, 2014).

1 in 7

4–7 year olds has had a mental health issue in the last year*.

1 in 6

of these children currently receives help*.

The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015)

Prevalence of infant and child mental health difficulties

Infants and young children

Despite a lack of empirical evidence, there is growing acknowledgment that we need to better understand the prevalence of mental health difficulties in infants, particularly those with coexisting trauma, disadvantage or insecure attachment concerns. In the US, Egger and Emde (2011) found that 8% of pre-schoolers met the criteria for more than one mental health difficulty. International epidemiological studies indicate that 16–18% of children suffer from a mental health difficulty at some time during their first five years (von Klitzing, Döhnert, Kroll, & Grube, 2015). An Australian study investigating a wide range of risk factors for adult mental health difficulties found that 16.1% of infants (0–1 years of age) had four or more risk factors, and that by the time children were 12–13 years old, 28.7% were exposed to four or more risk factors (Guy, Furber, Leach, & Segal, 2016). Adverse childhood experiences are strongly associated with poor physical and mental health outcomes in both the short and long term (Moore, McDonald, & McHugh-Dillon, 2014).

School-age children and young people

The 2015 *Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter)* provides detailed information on the prevalence of specific mental health difficulties (i.e. depressive disorder, anxiety disorders, attention deficit hyperactivity disorder [ADHD] and conduct disorder) among children and adolescents aged 4–17 years (Lawrence et al., 2015). This survey found that 13.6% of children (approximately one in seven) aged 4–11 years experienced mental health difficulties of clinical significance in the previous 12 months. Given that mental illness is associated with premature mortality (Joukamaa, 2001), unemployment (Butterworth, Leach, Pirkis, & Kelaher, 2012), delinquency (Fazel, Doll, & Langstrom, 2008), poor physical health (Boscarino, 2004) and suicide (Hawton & van Heeringen, 2009), among other poor outcomes, there is a clear need to intervene as early as possible in a child's life to improve these pathways. Despite this, the *Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter)* found that only one in six children who had a mental health condition in the previous 12 months had accessed a service for this condition.

Figure 1: Key elements of 'Keeping child mental health in mind: A workforce development framework for supporting infants, children and parents'.
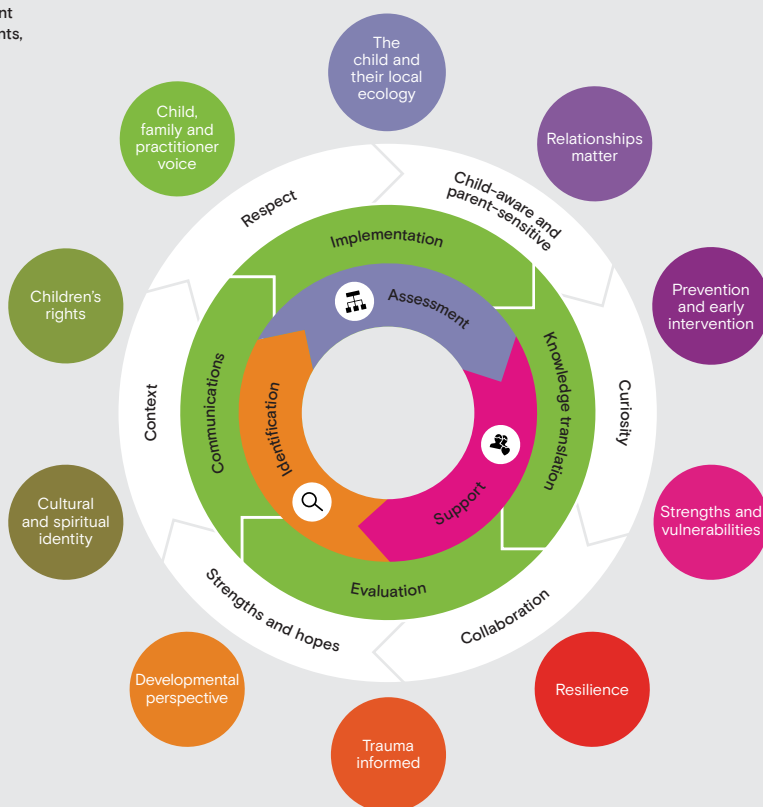
Key strategies of the National Workforce Centre

The National Workforce Centre has been established to assist professionals, service systems and organisations that work with children and/or parents in developing the skills to **identify, assess** and **support** children (aged 0–12 years) at risk of mental health difficulties. The National Workforce Centre supports health, social, and community services and practitioners to respond effectively to children's mental health, whether they work directly with children or not.

The National Workforce Centre incorporates three key components:

— an **online workforce gateway** for members of diverse fields to access resources such as practice guides, training, webinars, tools and apps

— a national network of regionally-based **Child Mental Health Workforce Consultants** to assist organisations to implement workforce development strategies that strengthen support for infant and child mental health; and

— a diffusion of evidence into practice via a strategic **communications plan** and **knowledge translation strategy.**

This publication provides high-level information regarding the key commitments that will underpin the strategies of the National Workforce Centre. These strategies will ensure increased awareness of mental health principles as they relate to practice and the Centre will work with professionals, organisations and sectors to support practitioner skill, knowledge and confidence in the identification, prevention and early intervention of mental health issues for infants and children. Specific strategies are outlined in more detail through a:

— knowledge translation strategy (p. 15)

— communications strategy (p. 16)

— implementation strategy (p. 17)

— evaluation framework (p. 18).

Figure 1: Key elements of 'Keeping child mental health in mind: A workforce development framework for supporting infants, children and parents'.
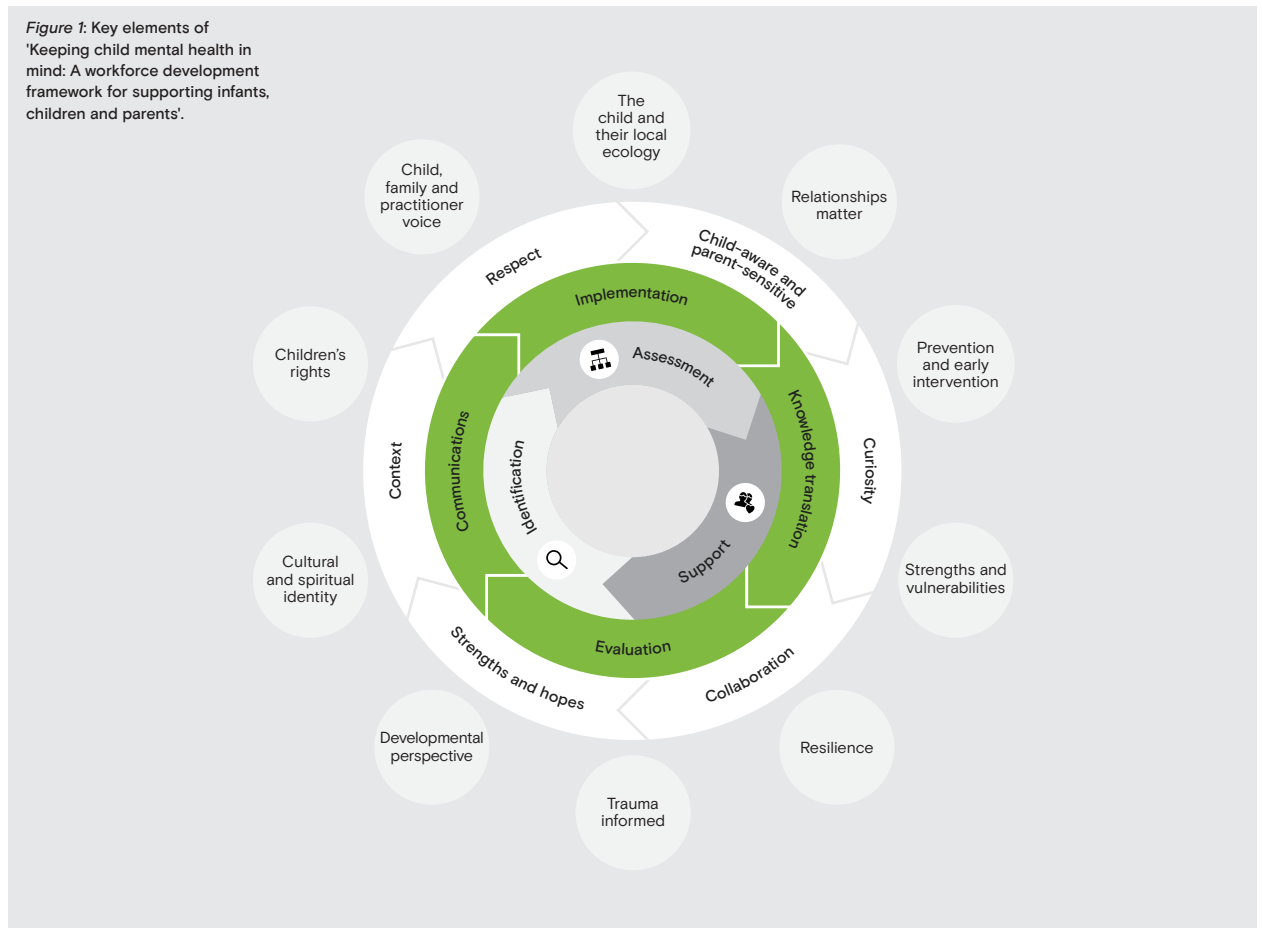
Knowledge translation strategy

A key component of the National Workforce Centre is a **knowledge translation strategy,** which supports the translation and dissemination of research evidence and knowledge about children's mental health into practice. Knowledge translation activities (e.g. the production of written and web-based resources) are designed to support stronger connections between research, practice and policy. Activities and resources include those that have been shown to effectively 'push' knowledge out to stakeholders; those that assist stakeholders to 'pull' information as needed; and those that facilitate the exchange and co-creation of knowledge between researchers, practitioners and families (Bennett & Jessani, 2011).

A number of key aims have been identified to focus the National Workforce Centre's knowledge translation activities, including:

— **brokering knowledge** between the research community and National Workforce Centre staff, to further build the Centre's capacity

— **building collaborations** between the National Workforce Centre and others with expertise in the field of infant and child mental health; and

— **generating practitioner awareness and knowledge** of children's mental health to inform and improve practice.

The National Workforce Centre takes an evidence-informed approach which considers knowledge from several key sources: current research (e.g. research and academic findings); practice-based evidence (e.g. skills and knowledge from practice); and the perspectives, preferences and actions of children, parents and families (i.e. their lived experience) (Bennett & Jessani, 2011).

Knowledge translation ensures that individuals and organisations who work with children and families are supported by the best available evidence and that they have the skills needed to identify, assess and support children at risk of or experiencing mental health difficulties.

Communications strategy

The National Workforce Centre for Child Mental Health takes a proactive and integrated approach towards marketing and communications, recognising the importance of this function in driving user engagement with its resources, practice tools and implementation supports.

The Centre's **communications strategy** focuses strongly on content marketing and as such, is closely connected to the knowledge translation strategy. It involves a mix of both digital and traditional marketing and communication activities.

The central focuses include:

— **increasing access and uptake** of the National Workforce Centre's resources, practice tools and implementation supports by professionals in the health, social and community sectors working with children, parents and families

— **growing the National Workforce Centre's networks** and uptake on a regional and national level

— **creating greater awareness** of infant and child social and emotional wellbeing among professionals in the health, social and community sectors; and

— **raising the profile** of the National Workforce Centre.

The strategy takes into account the unprecedented growth in online activity and digital behaviour that Australia and the globe have seen over the last several years. It also looks at the evolving ways that online information is accessed, along with the growing demand for video content, and is tailored to meet these changing needs.

The online components of the strategy are complemented by a series of offline activities which involve more traditional, face-to-face engagement with the Centre's key audiences.

To assess the effectiveness of this strategy, evaluation mechanisms have been identified and factored into the activity schedule over time. This allows the National Workforce Centre to track the progress of its communication activities and proactively respond and adapt.

Implementation strategy

Research indicates that while training and resource development activities support practice change, simply knowing what works is not enough (Fixsen et al., 2005). To effect real outcomes, an evidence-informed approach to supporting the implementation of practices within services and systems is also necessary. A structured approach to working with services, based on implementation science, can support this activity. Implementation science focuses on the use of strategies to adopt, integrate and use evidence-based interventions and practices to change practice patterns within specific settings (Fixsen et al., 2005). This approach can also bridge the 'knowledge-to-practice' gap, in conjunction with knowledge translation principles.

The National Workforce Centre uses the established evidence-informed implementation framework developed by the National Implementation Research Network (NIRN, 2015; Fixsen et al., 2005). In the NIRN framework, implementation strategies are used to assess, plan and track capacity-building efforts across the following phases of implementation:

— **Exploring:** This phase begins with recognising an opportunity for improvement and culminates in the development of an implementation roadmap that specifies the necessary changes required to achieve the implementation of new practices.

— **Installing:** This phase involves preparing the organisation for the implementation of new practices.

— **Implementing:** This phase involves ongoing monitoring and problem-solving once new practice approaches are in place.

The National Workforce Centre includes a team of Child Mental Health Workforce Consultants working to support the uptake and implementation of evidence-based practice approaches for identification, assessment and support in the promotion of children's mental health. These consultants are responsible for the development of high-level relationships with key stakeholders from health, social and community sectors and organisations working with children and/or their parents.

The activities that Child Mental Health Workforce Consultants undertake are tailored to the level and quality of the engagement they have with a given service provider. As a result, supports offered to service providers vary along a continuum, from 'light-touch' to more in-depth. More broadly, consultants are also responsible for building and supporting organisational and workplace culture to embrace a range of practices and attitudes aimed at 'keeping child mental health in mind'.

Evaluation framework

Children, parents and families have a right to receive high-quality services that are based on the best evidence of what will assist them (COAG, 2009), and they should expect that well-trained and well-supported professionals provide those services. However, the only way to really know if children, parents and families are receiving the services and support they need is through evaluation and continuous quality improvement. This involves a process of determining whether (and how) a program or practice achieves its objectives (i.e. evaluation), which then informs the development of practice and approaches (i.e. continuous quality improvement) (AIFS, 2013).

The evaluation framework of the National Workforce Centre is based on a theory of change in which improved workforce capacity is brought about through the combined impacts of a development of structural changes (e.g. policy and legislation, translation of evidence and data monitoring, workforce development framework), implementation and action planning focused on local needs, and addressing workforce issues (e.g. readiness, training, support and communications). To achieve a level of change in practice to promote child mental health, these changes need to be targeted across multiple layers, including at the national, regional, organisational and individual practitioner levels.

The evaluation framework involves a hybrid design methodology (Curran et al., 2012), which simultaneously measures the impact of the resources and activities of the National Workforce Centre (i.e. an impact or outcomes evaluation) and the effectiveness of the implementation strategy described above (i.e. an implementation or process evaluation). Both aspects of the hybrid design inform the other: the findings from the evaluation of the impact of workforce development resources will feed into a refinement of the knowledge translation and implementation strategies, while the findings from the implementation evaluation component will shape the development and delivery of future resources.

How we work

The Emerging Minds: National Workforce Centre for Child Mental Health partners with families, practitioners, organisations and communities to make a positive difference to the mental health of Australian infants and children. The National Workforce Centre conceptualises infant and child mental health using 10 Guiding Principles of Infant and Child Mental Health (see page 30). These Principles highlight key elements that underpin children's mental health and form the basis of the Centre's work.

The National Workforce Centre's values are outlined below:

Children's mental health is everyone's responsibility

All practitioners working with infants, children or parents should consider children's mental health as part of their work. Our work is guided by research acknowledging the role of children's ecology in their development and the significant impacts of adverse health, social and economic experiences on infant and child mental health. We promote an early intervention, prevention and trauma-informed lens to supporting infants and children, acknowledging that mental health exists on a spectrum and that risk can be dynamic.

We work collaboratively with professionals in the health, social and community sectors to support the mental health of infants and children. Bringing the child into focus while engaging with parents is an essential part of supporting parents and preventing infant and child mental health difficulties. Recognising the role of 'parent' is significant to addressing adult problems which impact on children.

Supporting children, parents and families in this context is complex and requires integrated and collaborative understandings of mental health. We bring together expertise from families, health, mental health, social services, community development, education, health promotion, implementation and change management to improve the way that workforces incorporate mental health into their interactions with infants, children, parents and families. This includes working together across child- and adult-focused services to reduce the impact of adversity and intergenerational vulnerabilities on children's key relationships, their daily lives and their mental health.

Nothing about us, without us

The National Workforce Centre partners with children, parents, families, carers, practitioners, researchers and organisations through the design, development and implementation of our resources.

We proactively include the voices of children, parents and families in the design of workforce development resources.

We are committed to listening to workforces and acknowledging areas of innovative and emerging practice, current challenges and areas for improvement. We maintain a position of curiosity with professionals about their needs and continually seek their feedback regarding the effectiveness of our resources.

We support and reinforce child-, parent- and family-centred practice approaches that prioritise curious and non-judgemental engagement with infants, children, parents and families. To achieve this, we ensure that our collaboration is respectful and allows children, parents and practitioners to share with us their stories of strength, hope and resilience as well as their challenges.

Strengthening capacity

We support organisations and practitioners to evaluate their current level of skill, knowledge, capacity and readiness for change. We help them to plan and implement changes designed to improve overall confidence in responding to the mental health needs of infants, children, parents and families.

Every interaction is designed to 'meet the workforce where it's at' and, as such, is tailored to the needs of the stakeholder. We provide wraparound online and face-to-face workforce support and learning and practice resources, and facilitate communities of practice to cement and sustain change.

The development of all content produced by the National Workforce Centre uses adult learning principles that focus on engagement, self-assessment and an understanding of the individual practice ethics of the practitioner or organisation.

Meeting needs with quality

We prioritise an understanding of the context of each professional, community, organisation and sector. We draw upon high-quality research evidence, practitioner expertise and lived experience when developing and critically evaluating our content to ensure that practice material is relevant and valuable.

We use robust continuous quality improvement principles to iteratively develop our services, guided by a thorough evaluation of our implementation and effectiveness in improving the mental health of infants and children.

Innovate and create

The work we do with children, families, practitioners and organisations is translated into modern and responsive digital products that connect in accessible and user-friendly ways. We work with artists, producers, and communications and digital professionals to make engaging, interactive and meaningful web-based resources, tools, videos and apps. Technology is an effective way of making knowledge and resources accessible to parents and practitioners in ways that achieve positive, practical outcomes in the lives of infants and children.

Our innovative knowledge translation and strategic communication approaches create opportunities to showcase stories of resilience, capability and strength, and build communities dedicated to improving infant and child mental health. Our inventive use of technology is supported by hard copy promotional material and human connection with families, practitioners and sectors.

Figure 2: The spectrum of mental health interventions

Source: adapted from Mrazek and Haggerty (1994)
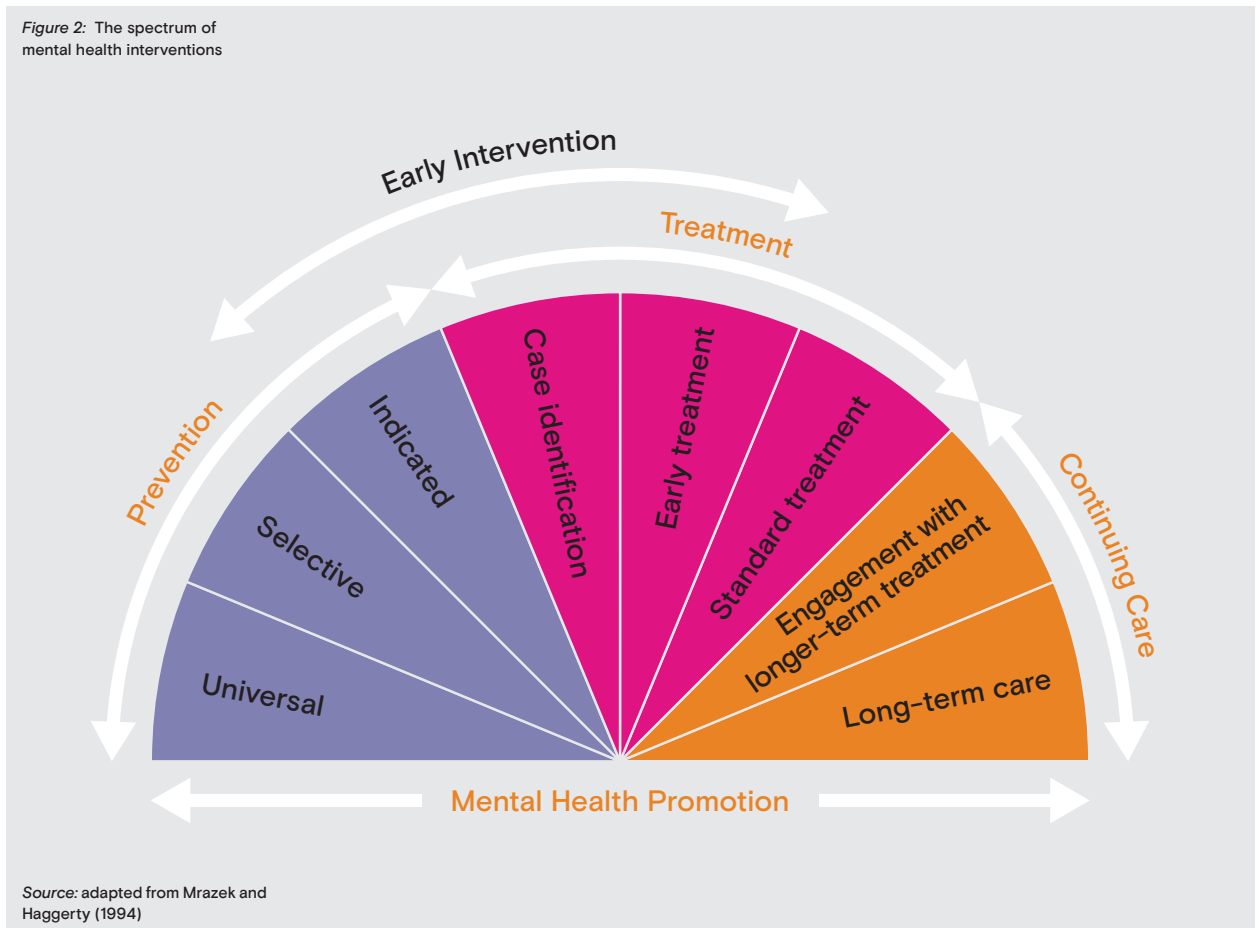
Spectrum of mental health interventions

Evidence has long supported a spectrum of mental health interventions ranging from promotion and prevention to early intervention and treatment. Figure 2 describes a core set of mental health services needed to decrease disorder incidence, duration, severity and premature mortality (Commonwealth Department of Health and Aged Care, 2000).

This framework focuses on infants and children at all levels of the mental health intervention spectrum, with a significant focus on prevention and early intervention strategies. These strategies include a range of health, social and community service providers to support engagement with children and parents to identify issues at the earliest possible time, through a holistic focus on infants and children's social and emotional wellbeing.

Current service provision

The *Young Minds Matter* survey indicated that 13.7% of all children aged 4–11 years had accessed a service for their mental health in the 12 months prior (Lawrence et al., 2015). Notably however, less than half (48.9%) of those children identified in the survey as having a mental health condition accessed services.

Children used a wide range of services for their mental health, including health services (provided by a qualified health professional), school services (within the child's school or other educational establishment), and telephone and online services (providing information, assessment, support, counselling or self–help programs). Of the children who received professional assistance, the percentages in contact with workforce groups or services were as follows:

%

%	Service
29.8	General Practitioner
22.5	Paediatrician
20.3	Individual Counselling in School
19.8	Psychologist
14.1	Counsellor or Family Therapist
13.9	Other School Services
13.1	Special Classes or Special School
10.9	Occupational Therapist
8.2	Other Health Services
6.5	Group Counselling or Support Programs in School
6.2	Social Worker
4.9	Psychiatrist
4.7	Hospital Emergency, Inpatient or Outpatient Services
3.5	School Nurse
0.9	Nurse

As this list demonstrates, there are many ways children, parents and families affected by child mental health difficulties access services.

Very few children under 12 years of age in the *Young Minds Matter* survey used telephone or online services. However, almost 40% of parents and carers of children and adolescents with mental health difficulties used the internet to find help or information. Most of these parents searched for information about mental health difficulties or services in their community, and about half used an online service such as personal support or counselling services, or an assessment tool.

Numerous factors were found to affect the level of service use among children with mental health difficulties, including the accessibility of regional services, household income, family type (e.g. blended, step, one carer or two) and parental education and employment status. The report showed that children and adolescents in families facing disadvantage and those with a sole parent were more likely to be identified as having a mental health condition. They were also more likely to have accessed support services for their mental health.

Other Australian research has shown that current levels of access to mental health services do not match current levels of need across the lifespan (Segal, Guy, & Furber, 2017). Specifically, infants, toddlers and primary–school aged children experiencing mental health difficulties have the lowest overall percentage of access to specialist mental health services. This means that there is a large disparity between need and service access.

A multi-sectoral approach

There is increasing cross-sector recognition that mental health issues should be identified early in all children. This acknowledges the need for coordinated and consistent universal health systems for infants and children that cater for the social, emotional and developmental wellbeing of every child, as set out in the National Framework for Protecting Australia's Children 2009–2020 (COAG, 2009).

The role of diagnosis in infants and children is oft-debated, with some research showing that mental health diagnoses can have negative effects on children and create stigma that paints the infant or child as the 'problem' (Merten, Cwik, Margraf, & Schneider, 2017). On the other hand, professional reluctance to identify mental health difficulties in infants and children can risk issues continuing into adolescence and adulthood. The National Workforce Centre works across health, social and community service sectors to support a holistic and cohesive understanding of infant and child mental health.

As can be seen in Table 1, the National Workforce Centre framework focuses on health, social and community services supporting children and/or adults who are parents. For services focused on the needs of infants and children, this framework aims to build workforce capacity to directly support the mental health outcomes of infants and children. For adult-focused services, this framework aims to support the adoption of family-focused practices that assist parents, other caregivers and families to integrate support for the mental health of children, in the context of adult health, mental health, disability and social issues that can affect nurturing relationships between adults and their children.

Table 1: Target workforce groups of the National Workforce Centre for Child Mental Health

Services focused on infants and children	— General practitioners — Primary and specialist health care providers — Child health and paediatric services — Child development services — Family mental health support services — Communities for Children — Child wellbeing programs and child protection services — Out-of-home care — Foster care support agencies — Playgroups — Child and family support services — Disability services — Aboriginal community-controlled health and welfare services — Early childhood education and care/schools
Services focused on parents and guardians	— General practitioners — Parenting programs — Community-managed mental health, alcohol and other drugs (AOD) and gambling social services — Family violence services — Homelessness services — Disability services — Family relationship services — First responder organisations — Aboriginal community-controlled health and welfare services — Primary and specialist health care providers — Adult mental health services — AOD treatment services

Note: Some workforce groups, such as general practitioners and Aboriginal community-controlled health and welfare services, appear in multiple categories because they support both children and parents.

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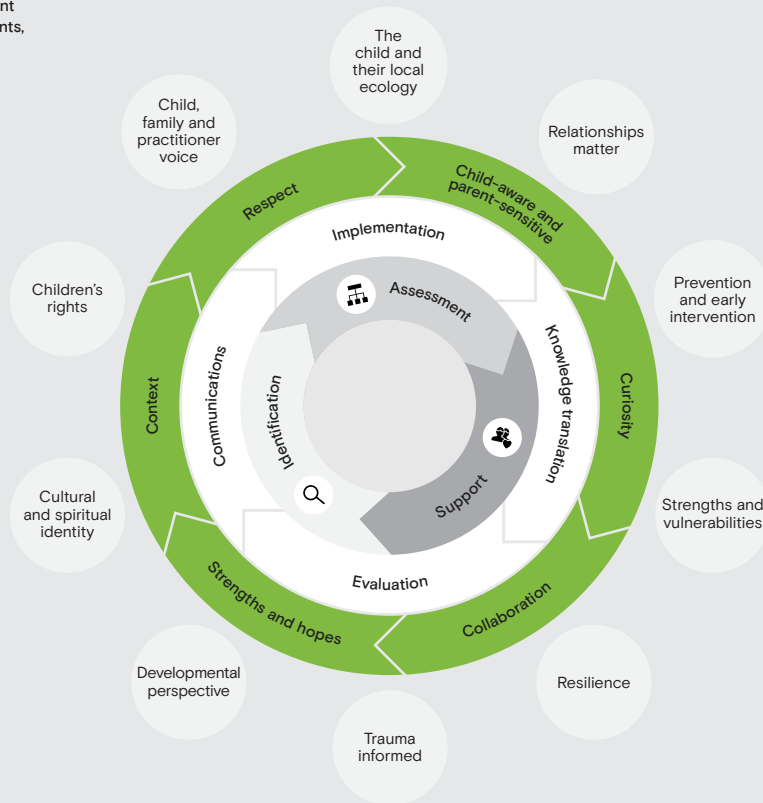
Our practice positions

One of the key aims of the National Workforce Centre is to encourage and support practitioners to authentically engage parents or caregivers in conversations about their parenting role and their child's wellbeing, and engage confidently with infants and children.

The National Workforce Centre has conducted extensive needs assessments with practitioners across many sectors which have informed us that, in the provision of child-focused and parent-sensitive practice, support is required to:

— regularly ask adults about their relationships with children

— work confidently and proactively to include children, where appropriate, in conversations about decisions that affect their lives

— navigate increasingly busy roles, while still finding time to prioritise the early identification and prevention of mental health difficulties for children

— increase confidence in the 'micro-skills' that are required to implement child-focused and parent-sensitive practice

— find time for the reflective practice that supports child-focused and parent-sensitive practice

— prioritise children's social and emotional wellbeing where parents and families present with many co-existing issues; and

— work with children and parents regarding issues that do not necessarily fit within their specialist practice area, where these groups present with coexisting issues.

To help guide this work, the National Workforce Centre has developed six practice positions that will guide much of its practice content. These positions support practitioners to consistently apply a child-focused lens in their work with children and parents.

These positions have been devised following conversations with individuals with lived experience of service delivery, who tell us that the single most important aspect of child-focused practice is to ensure that children are visible throughout every aspect of service delivery.

Our practice positions

1. Child-aware and parent-sensitive
practice in adult services recognises the need to ask parents about their relationship with their child. A child-aware approach acknowledges and considers the experiences of children so that they are visible within service delivery. A child-inclusive approach prioritises the involvement and consideration of children's social and emotional wellbeing in all aspects of decision making that affects their lives.
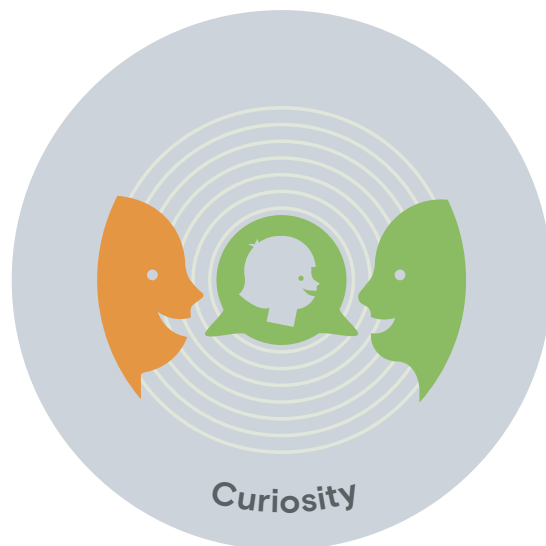
2. Curiosity
means more than asking questions to diagnose a problem: it allows for genuine understanding of children's and parents' daily lives. Being genuinely interested in the relationship of parents and children allows practitioners to consider the child's wellbeing as a prime motivator for change in the lives of parents. It also allows for conversations which focus on both strengths and vulnerabilities impacting on the parent–child relationship.

3. Collaboration
occurs where professionals work alongside children, parents and families to reach a shared understanding of their circumstances and concerns. Through this process, practitioners recognise that parents know their children's strengths and vulnerabilities and can collaborate on creating plans that support children's social and emotional wellbeing. Collaborative practice with children occurs where practitioners view them as genuine participants in the decisions that affect their lives.

4. Hopeful
conversations focus on the capacity of both children and parents to identify their strengths, skills, know-how and capabilities in overcoming adversities. This recognises times when adults have been able to parent in their preferred ways and the history of their care for their children. A focus on hopeful conversations recognises the interdependence of parents' hope for themselves and for the social and emotional wellbeing of their children. Through an application of this practice, stories of strength and hope, as well as challenges and vulnerabilities are more likely to emerge.
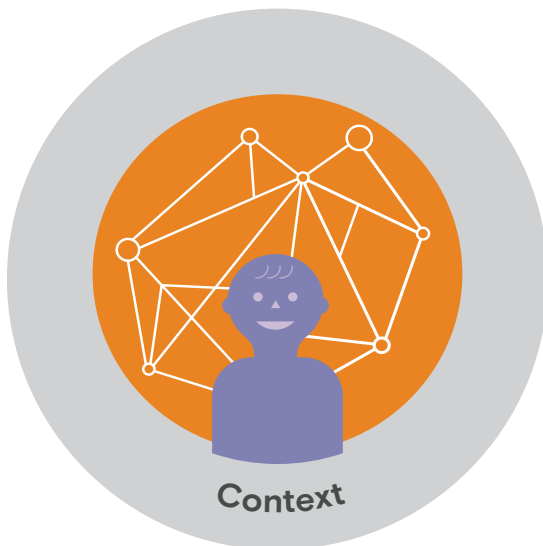
5. Contextual understandings
involve exploring circumstances that have contributed to the child's and parent's lives. A detailed history of the parent–child relationship, shaped by many different experiences and an understanding of the family's cultural, social and relational contexts will emerge through this exploration. Contextual understandings are key to providing culturally competent service delivery that caters to children and families from diverse cultures.
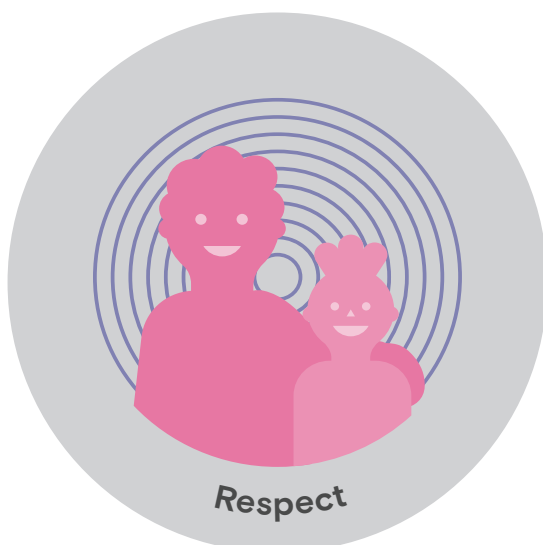
6. Respect
is built from the belief that children and parents can describe their preferences for the kinds of relationships and lives they would like. Respectful practice does not mean the compromising of a practitioner's stance around children's safety, but it does avoid the assumption that children or parents are unable to make decisions that positively affect their lives.

The following *10 Guiding Principles of Children's Social and Emotional Wellbeing* highlight key elements underpinning infant and child mental health. These principles form the foundation of the Emerging Minds: National Workforce Centre for Child Mental Health's work.

Guiding Principles

1 **Children and their local ecology**
The wellbeing of infants and children depends on their social and environmental contexts, more so than with any other age group. Infant and child mental health is best understood within a framework that accounts for individual child characteristics, family strengths and vulnerabilities, and broader social and economic factors.

2 **Relationships matter**
Relationships play a central role in children's social and emotional development and mental health. From the time of birth, children need stable and responsive relationships with caring adults.

3 **Prevention and early intervention**
A focus on preventing or intervening early in the progression of mental health difficulties not only benefits infants and children but also creates a solid foundation for health outcomes later in life, making it a long-term investment in the future of Australian society.

4 **Strengths and vulnerabilities**
At any point in time, children's mental health is influenced by a mix of strengths and vulnerabilities. Effective practice focuses on enhancing and promoting strengths, while accounting for vulnerabilities.

5 **Resilience**
Resilience is the ability to recover, adjust to, or grow after an adverse event or period of adversity. The single most important factor for developing resilience in children is the presence of at least one committed and supportive relationship with a parent, caregiver or other adult.

6 **Trauma informed**
Trauma involves experiences that overwhelm a person's ability to cope. Trauma-informed care is a framework for service delivery based on an understanding of the effect of trauma on individuals, their coping skills and service needs.

7 **Developmental perspective**
Children are not small adults; they have particular emotional, social and physical capacities and needs. To be effective, service delivery must be designed around infant and child developmental stages.

8 **Cultural and spiritual identity**
For some children and families, cultural and spiritual identity is central to health and wellbeing. Service provision is more effective if it respects and incorporates service users' cultural and spiritual understandings.

9 **Children's rights**
Upholding and protecting children's rights is essential to promoting their mental health. It is every adult's responsibility to uphold and fulfil the rights of children.

10 **Child, family and practitioner voice**
Services designed collaboratively with children, families and practitioners tend to be more effective, more acceptable to the individuals and families using the service, and more relevant to their local context.

Figure 1: Key elements of 'Keeping child mental health in mind: A workforce development framework for supporting infants, children and parents'.
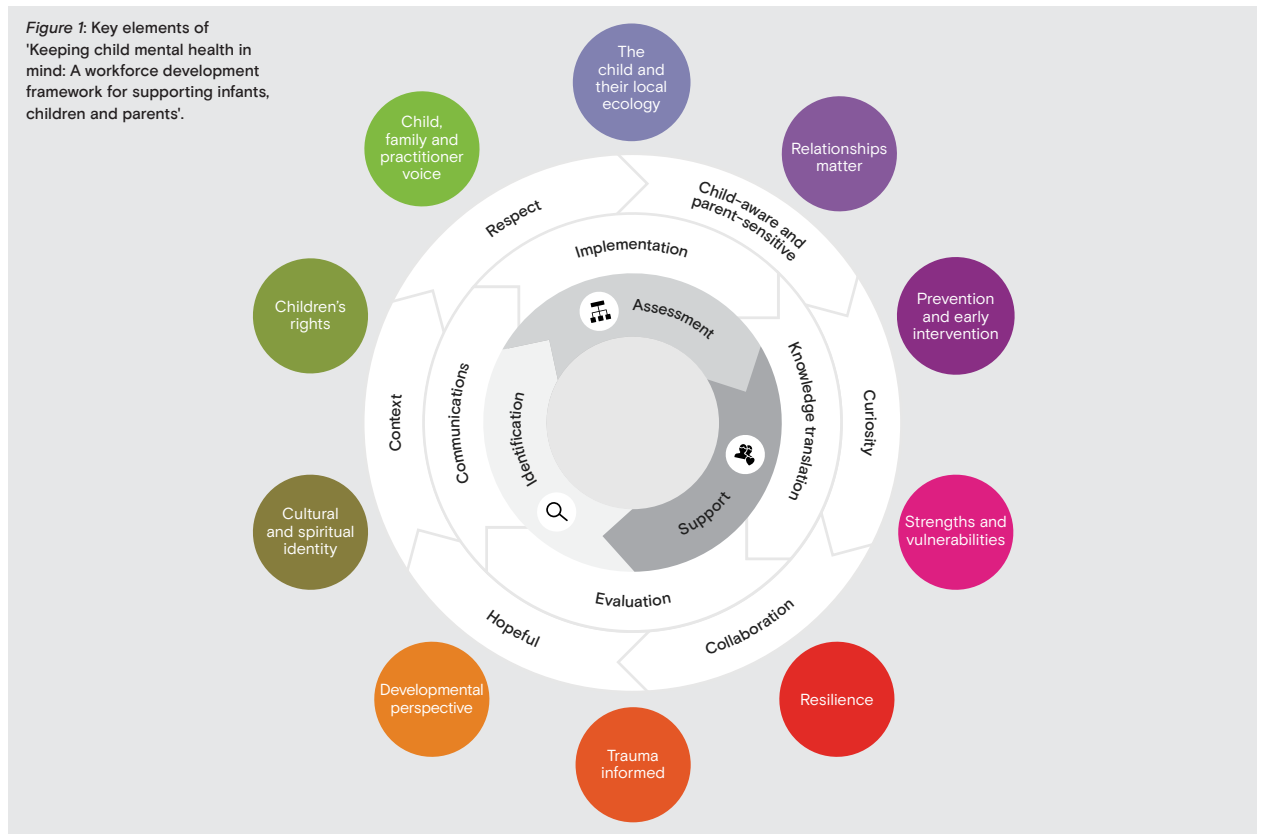
Background to the Guiding Principles

This section provides further information on the ideas and literature supporting each of the Guiding Principles outlined on the previous page.

1 Children and their local ecology

The wellbeing of infants and children depends on their social and environmental contexts, more so than with any other group. Infant and child mental health is best understood within a framework that accounts for individual child characteristics, family strengths and vulnerabilities, and broader community, social and economic factors.

Children's mental health cannot be separated from the broader contexts of their lives. This framework attempts to capture the many interacting influences on infant and child mental health, not least of which are children's relationships with their parents and their immediate family environment. The social ecological and biopsychosocial models, which are widely used in health and welfare service literature, are especially useful for encouraging a holistic perspective on mental health and wellbeing.

Social ecological models, such as Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1994), acknowledge that children's health and development occur within multiple contexts, including the family, school, local neighbourhood and community

environments, and that each of these environments is in turn influenced by broader social, economic, political and cultural factors. These contexts are interrelated and interdependent, meaning that changes in one can influence changes in others (Zubrick et al., 2008).

Child and adolescent mental health services in Australia often operate from a biopsychosocial perspective (Khan & Francis, 2015). The biopsychosocial model acknowledges biological (i.e. medical, physical and genetic), psychological (i.e. thoughts, emotions and behaviours) and social (i.e. support networks, family connections and environmental issues) factors as influences in the prevention, cause, presentation, management and outcomes of physical and mental health difficulties (Dogar, 2007).

Children are exposed to many experiences, both nurturing and stressful, which can have different effects on them as individuals. For children, it is normally the strengths and vulnerabilities of the family that provide the most powerful and enduring influences on health and social adjustment (Price-Robertson, Smart & Bromfield, 2010). Early childhood education and care services and schools provide another important context for children's development.

2

Relationships matter

Relationships play a central role in children's social and emotional development and mental health. From the time of birth, children need stable and responsive attachments with caring adults.

The most important influence on early brain development is the real-life 'serve and return' interactions with caring adults. As with a ping-pong ball being served and returned across the table, infants naturally reach out for interaction through babbling, facial expressions, gesturing and words, with the caregiver responding to them using the same kinds of vocalisation and gesturing (NSCDC, 2012).

The earliest years of life are a particularly sensitive time for brain development and secure relationships with a primary caregiver (Moore et al., 2017). If an adult's responses to a child are unreliable, inappropriate or absent, the damage to the developing architecture of the brain can have lifelong impacts on learning, behaviour, physical, mental and emotional health (NSCDC, 2012; Moore et al., 2017). Conversely, nurturing and enriching early life experiences provide the foundation for healthy brain development and increase the probability of positive outcomes in adulthood (Smart, 2017).

The importance of relational support for those children with compromised early beginnings continues beyond the first few years of life. However, children with positive early experiences are not immune to the impact of later adverse experiences and still require ongoing nurturing relationships (Moore et al., 2017).

The child's key relationships are with their immediate family, including parents and siblings. Other influences on the child include extended family members, and educators and peers, who play important roles as the child gets older. Children are also affected by the quality of relationships among the adults in their life, with exposure to domestic violence and family conflict having a negative impact on wellbeing (Smart, 2017; Kitzmann, Gaylord, Holt, & Kenny, 2003).

Other social and family problems can interfere with the quality of a child's relationships and interpersonal interactions, such as significant stress associated with economic hardship, social isolation, alcohol and other drug use, and physical and mental health problems. The nature of these vulnerabilities is that they are often enduring, can fluctuate in severity over time, and can impede a parent's ability to provide nurturing interactions (National Research Council and Institute of Medicine, 2009).

The interdependent nature of the parent–child relationship also means that difficult child behaviour or the demands of child rearing can in turn unsettle the nurturing environment. The relationship between child and parent or other caregivers is inherently linked and flows in both directions. The cumulative impact over time of disrupted relationships can lead to difficulties in social adjustment, mental health problems and chronic physical disease (NSCDC, 2012).

3

Prevention and early intervention

A focus on preventing or intervening early in the progression of mental health difficulties not only benefits infants and children, but also creates a solid foundation for health outcomes later in life, making it a long-term investment in the future of Australian society.

Prevention and early intervention activities can occur early in life and/or early in the progression of a mental health difficulty. An early-in-life focus on mental health not only benefits children and families but also creates a solid foundation for outcomes later in life. Wellbeing in childhood is associated with a range of positive outcomes, including higher academic attainment, economic security and improved social relationships (VicHealth, 2015a).

Parents and extended family are clearly instrumental in the mental health and wellbeing of infants and children. Factors that have an impact on mental health in childhood often arise from or are influenced by family, and therefore, addressing strengths and vulnerabilities in parents' lives will also protect children.

Prevention of mental health problems refers to interventions that occur before the initial onset of a condition to prevent its development (Mrazek & Haggerty, 1994). Prevention interventions aim to identify and modify factors and environments that are associated with mental health difficulties. These factors include perinatal influences; family and other interpersonal relationships; schools and workplaces; sports, social and cultural activities; media influences; and the physical and mental health of individuals and communities.

Early intervention programs aim to prevent progression from the early signs and symptoms of a mental health condition to a diagnosable condition. These programs include interventions that are appropriate for people developing or experiencing the first episode of a mental health difficulty. Early intervention aims to reduce the impact in terms of duration and damage and foster hope for future wellbeing.

The importance of the involvement of services beyond those focused on mental health is critical for prevention and early intervention. These services include not only health, family and community services, but also sectors such as sports, arts, business, education, labour, justice, transport, environment and housing (World Health Organization [WHO], 2018). Also important are inter-sectoral strategies, such as those aimed at the socio-economic empowerment of women, violence prevention and poverty reduction, as well as coordinated responses between infant, child, adolescent, adult and aged service providers and systems (WHO, 2018).
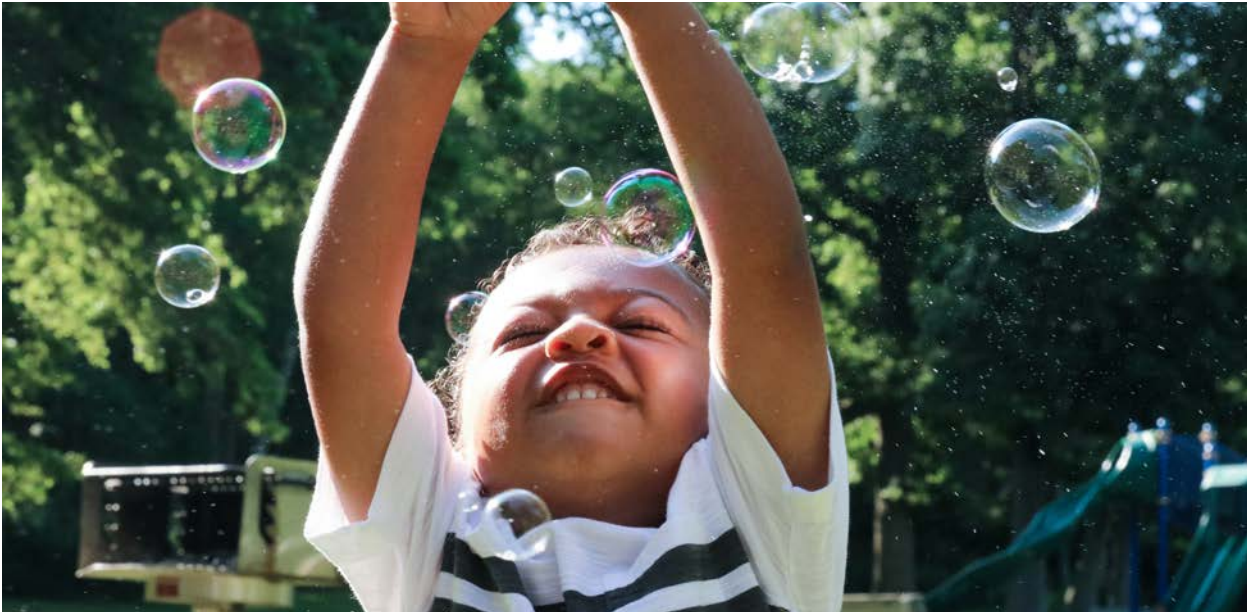
4

Strengths and vulnerabilities

At any point in time, children's mental health is influenced by a mix of strengths and vulnerabilities. Effective practice focuses on enhancing and promoting strengths, while accounting for vulnerabilities.

An understanding of both the strengths and vulnerabilities influencing infants, children and families is critical to working with individuals and families with complex issues (Scott, Arney, & Vimpani, 2013). 'Strengths' are areas of children's lives that enhance their wellbeing, such as family and school connectedness, prosocial behaviour, developmentally appropriate emotional and behavioural responses, and positive peer and adult relationships. Strengths-based approaches employ theories and strategies that focus on children's and families' capabilities and resources, rather than their deficits and pathologies. Individuals' abilities, resources, personal characteristics, interests and wishes are all taken into consideration and seen as motivators and tools for positive change. Such approaches are built on the premise that the normal human development process tends towards healthy growth and fulfilment, and that everyone has strengths that will aid them in this process (Hunter, 2012).

'Vulnerabilities' are areas of the child's life that may be of concern or could benefit from further attention and support. They include individual factors, such as developmentally inappropriate emotional and behavioural responses (e.g. a difficult temperament or problems managing emotions); family factors, such as parental stress and problems (e.g. alcohol and other drug misuse or mental health difficulties); and social factors, such as negative experiences in the community (e.g. discrimination or isolation) (Hunter, 2012).

Vulnerabilities are complex and interconnected, and it is common for infants and children to face multiple vulnerabilities (Guy et al., 2016; Zeanah & Zeanah, 2009). Individual, family and social factors all contribute significantly to mental health outcomes of infants and children. Children in out-of-home care, for example, are more likely to have experienced greater socio-emotional and behaviour problems than other children. Similarly, children exposed to the impact of parental problems have a significantly greater risk of developing emotional symptoms.

This publication uses the term 'strengths and vulnerabilities', while others use the term 'risk and protective factors', which is often associated with more formal assessment tools and policies. There are many similarities between these terms, and for the purposes of this framework, they may be used interchangeably.

Underlying the effective use of the strengths and vulnerabilities framework is the practice of curiosity that allows families the opportunity to tell their stories in an environment that is curious, non-judgemental and supportive.

5

Resilience

> **Resilience is the ability to recover, adjust to, or grow after an adverse event or period of adversity. The single most important factor for developing resilience in children is the presence of at least one committed and supportive relationship with a parent, caregiver or other adult.**

Resilience is an important concept in many areas of health and welfare service provision. Like a strengths-based approach, it is important because it directs attention towards people's capacities to successfully navigate difficult circumstances. Resilience and mental health are related concepts, with many practices that promote mental health also promoting resilience (Hunter, 2012).

While adversity is a part of life and everyone experiences stressful events from time to time, some children shoulder a much greater burden than others through circumstances such as poverty, abuse, traumatic events, domestic violence, and illness. However, despite significant early life adversity, some children will still progress through life and have positive outcomes. Understanding why one child can do well despite exposure to multiple adversities, while another's life trajectory is severely disrupted as a result, is important for developing programs and services to help children reach their full potential (VicHealth, 2015b).

One of the key findings to emerge from decades of research on resilience is that having at least one stable and supportive relationship (e.g. where routines are maintained during the stressful period) with a parent, caregiver, or other adult is essential to positive adaptation following adversity (NSCDC, 2015). The presence of a responsive relationship provides the safe and nurturing environment within which children can practise different adaptive strategies and develop executive function capacities, such as goal setting and problem solving, and self-regulatory capacities such as impulse control. When attuned adults provide opportunities and support for children to adapt to stressful events, it generates positive experiences of coping with adversity. Family and social environments that affirm children's faith or cultural traditions have also been shown to lead to more positive outcomes following adversity.

The accumulation of successful adaptive experiences, within the context of positive relationships, builds resilience. Resilience is best understood as a process which continues to develop throughout a person's life, rather than an outcome. This means that a child may show resilience in response to one event and not another. The importance of child-adult relationships in the development of resilience means that the resilience of the adult in the relationship also matters.

Evidence clearly demonstrates that inherent characteristics, together with features of the family and social environment (in particular caring relationships) determine resilience in children. It is not simply a set of individual competencies that can be taught.

6

Trauma informed

Trauma involves experiences that overwhelm a person's ability to cope. Trauma-informed care is a framework for service delivery based on an understanding of how trauma affects people's lives, coping skills and service needs.

Trauma-informed care can be described as a framework for service delivery that is based on knowledge and understanding of how trauma affects people's lives (Harris & Fallot, 2001). It involves a range of practices that are directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and adversity on an individual, and an appreciation for the high prevalence of experiences of trauma and adversity among children and young people in the community. Trauma-informed care requires consideration of children's whole environment and their experiences, and of how their symptoms, feelings and behaviours may be seen as adaptations to trauma rather than as pathologies (Herman, 1992). At the very minimum, trauma-informed services aim to do no further harm through re-traumatising individuals, by acknowledging that services-as-usual may provide inadvertent triggers that exacerbate trauma symptoms.

Trauma is often a result of adverse childhood experiences (ACEs), which are defined as perceived negative events that are outside the control of the child,

may hinder normal development, cause harm or the potential for harm, and are accompanied by stress and suffering (Burgermeister, 2007). ACEs include family difficulties related to financial struggles, family health problems and losses, family and domestic violence, and parenting impairment (e.g. due to a mental health condition or alcohol and other drug (AOD) misuse). ACEs contribute to increased vulnerability to mental health difficulties in childhood, adolescence and adult life (Raphael, Stevens, & Pedersen, 2006; Dube et al., 2003). An accumulation of multiple adverse experiences can increase the risk of mental health problems that can in turn impair social and emotional functioning (Benjet, Borges, & Medina-Mora, 2010).

How a child responds psychologically to trauma, loss and other adverse experiences varies with the child's development and supportive relationships (Fearon & Belsky, 2004). The long-term outcome of trauma and adversity includes changes in children's stress system and hormones, which can affect their developing brain structure and functioning (Schore, 2002). This can lead to struggles with internalising and externalising problems, such as the regulation of feelings, relationship insecurity, poor socialisation, hyperactivity, disruptive behaviour and poor impulse control. ACEs are also known to be strongly correlated with adult physical health problems such as smoking, diabetes, AOD misuse, obesity and heart disease (Flaherty, Thompson, & Litrownik, 2009).

7

Developmental perspective

> **Children are not small adults; they have particular emotional, social and physical capacities and needs. To be effective, service delivery must be designed around infant and child developmental stages.**

Children's mental health needs to be understood within a developmental context (Miles et al., 2010). Infant and child mental health are often described with a focus on the development of capacities such as forming close and secure relationships, exploring environments and learning, and regulating and expressing emotions (Miles et al., 2010). These capacities are established in different ways for children of different ages (Miles et al., 2010). As such, prevention or intervention strategies used with children at risk of, or experiencing, mental health difficulties need to be appropriate to the developmental level of the individual infant or child, and reflective of approaches that are relevant and applicable to each age group (Australian Infant, Child, Adolescent and Family Mental Health Association, 2011).

The signs and symptoms of mental health difficulties, and the types of interventions that are appropriate, will differ depending on the developmental stage of infants and children:

— **0–2 years:** Symptoms may include taking no pleasure in interacting with their parents; crying easily or continually; having disturbed sleeping and eating cycles; or appearing passive, unreceptive or unhappy. Identifying mental health difficulties in infants and young children can be a difficult task, as it is normal for children to demonstrate some of these symptoms at certain times in their lives. As there are many potential causes, diagnosis and treatment would usually be carried out by specialists and interdisciplinary teams (von Klitzing et al., 2015).

— **2–4 years:** Symptoms may include a lack of interest in play; pronounced separation anxiety; and problems with eating, sleeping and toileting. When behavioural or emotional problems such as these start to significantly interfere with children's capacity to function, there may be cause for concern. Interventions may include cognitive behavioural therapy or parent–child interaction therapy (von Klitzing et al., 2015).

— **5–8 years:** Early primary school-aged children may begin exhibiting the signs and symptoms typically associated with depression and anxiety, such as persistent sadness, moodiness, lack of motivation, loss of hope, fear of social situations, and sleeping difficulties. In addition to school-based interventions, family interventions may be appropriate at this age (Herzig-Anderson et al., 2012).

— **8–12 years:** Children in the later primary years may exhibit similar signs and symptoms as those in early primary school. However, their experiences may be affected by issues such as increasing independence, developing social capacities, and physical development (including early puberty).

8

Cultural and spiritual identity

For some children and families, cultural and spiritual identity is central to health and wellbeing. Service provision is more effective if it respects and incorporates service users' cultural and spiritual understandings.

A strong, positive sense of cultural and spiritual identity is important to children's mental health, particularly in generating self-esteem, resilience and a sense of belonging (SNAICC, 2012). Studies of cross-cultural parenting practices reveal that almost all aspects of child rearing are shaped by culture. For example, culture influences when and how parents care for children, what is expected of children, and which behaviours are rewarded and punished (Bornstein, 2013). Even if families do not identify with cultural or spiritual traditions, it is likely that they have inherited or established routines and traditions that contribute to a positive sense of family identity.

In their early years, children become sensitised to differences among people and may be exposed to racism and prejudice, which can profoundly impact their social and emotional wellbeing, learning and social relationships. Children with a strong cultural identity are well placed to make positive social connections and feel a sense of belonging to their community, even if the culture of that community is different from that of their family (Usborne & Taylor, 2010). Spiritual identity entails identifying with a particular belief system and is deeply important for many children and families. Spiritual identity may or may not be associated with organised religion or belief systems.

The impact of migration on families can vary between skilled migrants and humanitarian migrants (asylum seekers/refugees). Seeking asylum often means that families have gone through traumatic experiences in their home country (e.g. persecution, torture, war) as well as on their journey to Australia (e.g. family separation, dangerous voyages, indefinite detention). Although the migration process of skilled/economic migrants seems to have little impact on the mental health and wellbeing of infants and children, there is international evidence that second- and third-generation migrant children can have elevated rates of mental health problems (Georgiades et al., 2018). The broad social determinants of health such as poverty, isolation, parental separation, maternal mental health, and where the person lives all have an impact (Alati et al., 2003). Other factors that differentiate the migrant communities from the broader community include experiences of racism, the unique cultural perspectives of mental health, duration of stay in their new country, proficiency in English, and the strength of family ties. US research also indicates that children of immigrant parents are less likely to receive mental health services (Georgiades et al., 2018).

The diversity of cultures that make up Australian society poses a unique challenge for practitioners in delivering services, and it is important for practitioners to engage with families in ways that respect their cultural and spiritual identities. Such identities can inform the explanatory models families use to understand mental health difficulties, and treatment is unlikely to be successful if these understandings are not used during each phase of the intervention.

9

Children's rights

Upholding and protecting children's rights is essential to promoting their mental health. It is every adult's responsibility to uphold and fulfil the rights of children.

As a signatory to the United Nations Convention on the Rights of the Child (CRC) (United Nations Human Rights Office of the High Commissioner, 1990), Australia has a responsibility to ensure that children's best interests are reflected in policy and program planning, and that children are widely supported to participate in the decisions that affect their lives.

The CRC stipulates that children have the right to:

— have the protection, support and care necessary for their wellbeing

— participate and be heard in discussions and decisions that will affect them (when they are capable of forming their own views)

— be brought up by their own family, unless it is contrary to their best interests

— maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the children's best interests

— have access to education and information that is linguistically, culturally, psychologically and developmentally appropriate (particularly if it will promote their social, spiritual, physical and mental health); and

— have access to the highest attainable standards of health and a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

While the rights of children set out in the CRC are of equal importance, the right to be heard underpins the application of all CRC rights (Australian Human Rights Commission [AHRC], 2016).

We also note that the rights of infants and toddlers warrant special attention as they are even more easily overlooked in service settings, and are guided by the principles outlined in the Position Paper on the Rights of Infants developed by the World Association for Infant Mental Health (2014).

The Australian Human Rights Commission (2017) has identified children with mental health issues as being at risk of falling through the service gaps, with poor participation opportunities being a key vulnerability. It is therefore paramount that mental health service delivery is guided by the CRC.

The National Workforce Centre supports children having input into the discussions and decisions surrounding their mental health. Giving children opportunities to be involved in decision-making processes and to freely express their needs can empower them and increase their likelihood of accessing and trusting in service systems (Moore, 2017). Having child-centred processes in place can also enhance decision-makers' understandings of children's experiences, foster more positive attitudes towards children, and ultimately improve service responses (Moore, 2017).

10

Child, family and practitioner voice

Services designed collaboratively with children, families and practitioners tend to be more effective, more acceptable to the individuals and families using the service, and more relevant to their local context.

Engaging with, and listening to, the views of children, families and practitioners is a strategy used to improve outcomes for children and their families (Moore et al., 2016). Such engagement implies more than simply consulting with children, families and practitioners. Indeed, it has been defined as 'a process whereby a service system:

— seeks out community values, concerns and aspirations proactively

— incorporates those values, concerns and aspirations into a decision-making process or processes; and

— establishes an ongoing partnership with the community to ensure that the community's priorities and values continue to shape services and the service system' (Moore et al., 2016, p. 19).

Service provision for child mental health is a collaborative process that involves the cooperation and input of everyone involved – professionals, children, and parents and other family members. When striving to include child, family and practitioner voices, it is important to establish partnerships among these different groups so that the needs and perspectives of each group may be understood by all involved.

The inclusion of child, family and practitioner voices is particularly important in disadvantaged communities, where services may not be accessed by vulnerable and marginalised families with complex needs (Moore et al., 2016). Children and families with the most complex problems are less likely to access services, and more likely to cease involvement with services (Head, 2011).

The views of children should be heard in a way that is age-appropriate (Moore et al., 2014). Research has found that children want to be more involved in their care and that children as young as four years have demonstrated competence in 'analysing and discussing issues that are of importance to them' (Coyne, 2006, p. 69). In addition to enhancing services, listening to children's voices fulfils child rights principles and can have developmental benefits for the children and families involved (Coyne, 2006).

The National Workfore Centre aims to lead by example in partnership and co-production strategies. This involves ensuring that the implementation of workforce development resources is informed by the practice experiences of professionals and the lived experience of children, parents and family members, and considered in the contexts of culture and community. It also involves the development of resources that assist organisations to implement partnership and co-production strategies themselves.

Term	Description
Aboriginal and Torres Strait Islander	'A person of Aboriginal or Torres Strait Islander descent, who identifies as being of Aboriginal or Torres Strait Islander origin and who is accepted as such by the community with which the person associates' (University of Western Sydney, 2016, para. 1).
Aboriginal community controlled health service	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management (National Aboriginal Community Controlled Health Organisation, n.d).
Adolescent	A person aged 12–18 years.
Adult mental health service	An organisation that provides, as its core business, primary, secondary and, in some cases, tertiary treatments and supports to adults with diagnosed mental health difficulties.
Adverse childhood experiences	Perceived negative events that are outside the control of the child, which may hinder normal development, cause harm or the potential for harm, and are accompanied by stress and suffering (Burgermeister, 2007).
Assessment	In the context of this workforce development framework, assessment involves developing an understanding of the strengths and vulnerabilities that influence a child's mental health. If appropriate, assessment may also entail the use of clinical assessment tools.
Asylum seeker	A person who has fled their own country and applied for protection as a refugee (Australian Human Rights Commission, 2017).
Biopsychosocial model	The biopsychosocial model acknowledges biological, psychological and social factors as influences in the prevention, cause, presentation, management and outcomes of physical and mental health difficulties (Dogar, 2007).
Child	A person aged 0–12 years.
Child and adolescent mental health services	An organisation that provides, as its core business, primary, secondary and, in some cases, tertiary treatments and supports to children and adolescents with mental health difficulties.
Child development service	An organisation that provides support for children who experience developmental difficulties in areas such as coordination and movement, speech and language, social and emotional skills, play and learning.
Child health services	Organisations that provide support to children (up to 12 years old) who have mild to moderate developmental difficulties and behavioural issues. To do so, child health teams provide coordinated, community-based, multidisciplinary services.
Child protection service	An agency operating under state/territory legislation relating to the care and protection of children. Services provided include investigation into concerns regarding child maltreatment, assessment, case planning, protective intervention and supervision of children and families under relevant court orders.
Clinical services	For the purposes of this workforce development framework, clinical services are those whose model of practice is based on the diagnosis and treatment of mental health difficulties. Clinical services can be compared to non-clinical services, which tend to focus on recovery, empowerment, case management and the social determinants of health.
Communities for Children	An area-based Government initiative designed to ensure children have the best start in life by focusing on prevention and early intervention approaches that bring about positive family functioning, safety and child development outcomes for children and their families in disadvantaged communities throughout Australia (Department of Social Services, 2017).

Disability	'A person has a disability if they report that they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities' (Australian Bureau of Statistics [ABS], 2015, pg. 27).
Early childhood	The first five years of childhood, with the first two to three years identified as an especially significant period of development.
Early childhood education and care	Refers to organisations that provide childcare (e.g. long day care) and/or education in the year before school (e.g. pre-school or kindergarten).
Early intervention	Early intervention aims to prevent progression from the early signs and symptoms of mental health difficulties to a diagnosable condition, and includes interventions that are appropriate for people developing or experiencing the first episode of a mental health condition (Mrazek & Haggerty, 1994).
Engagement	The process of working together with parents to provide support, including initial contact and meaningful participation for the period over which support is required.
Evaluation	The process of systematically determining whether (and how) a program or practice achieves its objectives (Parker, 2013).
Evidence-based practice	A process through which professionals use the best available evidence integrated with professional expertise to make decisions regarding the care of an individual, family, group or community.
Exploring	As the first phase in the National Implementation Research Network (NIRN) implementation framework, the exploring phase begins with recognising an opportunity for improvement and culminates in the development of an implementation roadmap that specifies the necessary changes required to achieve the implementation of new practice approaches (NIRN, 2015).
Family	There is wide variation in the composition of Australian families, which can include combinations of mother, father, same-sex parents, stepmother, stepfather, infants, children, adolescents, other family members, and non-related carers.
Family and domestic violence	Family and domestic violence refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Examples of types of behaviour include acts of physical aggression such as slapping and kicking; psychological (emotional) abuse such as intimidation and threats to take away children; sexual violence; and controlling behaviours such as isolating a person from their family and friends (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).
Family-centred care	This involves working in partnership with children and their families in the delivery of health care. It includes responding to the needs of the children and their families, and respecting their preferences, values, cultural background and traditions.
Family mental health support service	An organisation that provides early intervention support to assist vulnerable families with children and young people (up to 18 years old) who are at risk of, or affected by, diagnosed mental health difficulties.
Family relationships service	An organisation that offers support and education to families experiencing family relationship difficulties, including families with children who are at risk of separating, or who have separated.
First one thousand days	The first one thousand days of a child's life (roughly spanning the period between conception to age 2) are the most important in terms of their development, learning and long-term social and emotional wellbeing. Challenges faced by adults, such as mental health issues, obesity, heart disease and poor literacy and numeracy, can be traced back to pathways that originated in early childhood (Moore, Arefadib, Deery, Keyes, & West, 2017).
Gender dysphoria	'The distress or unease sometimes experienced from being misgendered and/or when someone's gender identity and body personally don't feel connected or congruent. Gender dysphoria does not equal being trans or gender diverse. Many trans and gender diverse people do not experience gender dysphoria and if they do it may cease with access to gender affirming health care.' (ACON Language Guide, 2017)

Homelessness	'When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement: is in a dwelling that is inadequate; or has no tenure, or if their initial tenure is short and not extendable; or does not allow them to have control of, and access to space for social relations' (Australian Bureau of Statistics [ABS], 2012, 'Homelessness statistics', para. 6).
Identification	In the context of this workforce development framework, identification involves recognising a vulnerability in relation to a child's mental health.
Implementation science	'The study of factors that influence the full and effective use of innovations in practice. The goal is not to answer factual questions about what is, but rather to determine what is required' (National Implementation Research Network [NIRN], 2015, para. 3).
Implementing	As the third phase in the NIRN implementation framework, implementing involves ongoing monitoring and problem-solving once new practice approaches are in place (NIRN, 2015).
Indicated interventions	Indicated interventions are targeted at those identified as having the early signs and symptoms of mental health conditions but who do not meet the diagnostic criteria at that time. Even if the individual eventually develops a disorder, the duration and/or severity may be reduced (Mrazek & Haggerty, 1994).
Infants	Children aged less than one year.
Installing	As the second phase in the NIRN implementation framework, installing involves preparing an organisation for the implementation of evidence-informed practice approaches (NIRN, 2015).
Intergenerational disadvantage	Intergenerational disadvantage refers to the phenomenon in which economic, political and social hardship is passed from one generation to another due to the lack of opportunities, exclusion and impoverishment experienced throughout childhood and early adolescence.
Knowledge translation	The synthesis, exchange, application, and dissemination of knowledge by relevant stakeholders to improve health and the delivery of health care. Synthesis is the 'contextualisation and integration of the findings of individual research studies within the larger body of knowledge on the topic' (Graham, 2012, 'Overview', para. 1) and can include systematic reviews or scoping reviews. Exchange may include partnerships and 'collaborative problem-solving' between service providers and service users in the research process, or researcher and knowledge user. Dissemination involves the sharing of research findings through a research report, a webinar, a post on Facebook and more, and application is the process of putting research knowledge into practice (Canadian Institutes of Health Research, 2016; Sibley & Salbach, 2015).
Mental health	This is a state of wellbeing in which people can realise their potential, cope with the normal stresses of life, work productively, and contribute to their communities (World Health Organization [WHO], 2018).
Mental health condition	A significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable condition. Commonly diagnosed child mental health difficulties include depressive disorder, anxiety disorders, attention deficit hyperactivity disorder (ADHD) and conduct disorder.
Non-binary	'An umbrella term for any number of gender identities that sit within, outside of, across or between the spectrum of the male and female binary. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender, etc.' (ACON Language Guide, 2017).
Out-of-home care	Out-of-home care refers to the care of children and young people up to 18 years who are unable to live with their families (often due to child abuse and neglect). It involves the placement of a child or young person with alternate caregivers on a short- or long-term basis.

Playgroups	Playgroups provide developmentally appropriate play opportunities for children and opportunities for carers to develop social and support networks. The two main forms of playgroup are community playgroups, which aim to include all families, and supported playgroups, which aim to support families with particular needs or vulnerabilities and are run by at least one paid facilitator (Commerford & Hunter, 2017).
Prevention	Prevention occurs before the initial onset of mental health difficulties, and includes interventions that aim to identify and modify factors that determine mental health difficulties.
Primary health networks	An administrative health region established to deliver access to primary care services for patients, as well as coordinate with local hospitals in order to improve the overall operational efficiency of the network (Department of Health, 2015).
Refugee	A person who is outside their own country and is unable or unwilling to return due to a well-founded fear of being persecuted due to their race, religion, nationality, membership of a particular social group or political opinion. (Australian Human Rights Commission, 2017).
Resilience	Resilience is the ability to do well during or after an adverse event, or period of adversity. The single most important factor for developing resilience in children is the presence of at least one committed and supportive relationship with a parent, caregiver or other adult.
Selective interventions	Selective interventions are targeted at individuals 'whose risk of developing mental health conditions is significantly higher than average, as evidenced by biological, psychological or social risk factors' (Mrazek & Haggerty, 1994, p. 23).
Social determinants of health	The conditions in which people are born, grow, live, work and age. These life circumstances are shaped by the distribution of money, resources and power at local, national and global levels (WHO, 2018).
Social ecological model	A theory-based framework for understanding the complex interplay between individual, relationship, community, and societal factors.
Strengths	Attributes or conditions at the individual, family or social levels that moderate risk or adversity and promote mental health.
Support	In the context of this workforce development framework, support involves providing access to information, delivering an intervention and/or activating support networks.
Trans and gender diverse	'Umbrella terms that describe people who identify their gender as different to the legal sex that was assigned to them at birth.' (ACON language guide, 2017)
Trauma-informed care	A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs.
Vulnerabilities	Attributes or conditions at the individual, family or social levels that increase the probability that a child will experience adversity, including possible mental health difficulties or a mental health condition.
Young person	A person who is 12 years old or older, but not yet an adult (ACT Parliamentary Council, 2008).

References

ACON. (2017). A language guide: Trans and gender diverse inclusion. Retrieved from: <http://www.transhealthsa.com/wp-content/uploads/2018/02/ACON-Trans-Inclusion-Language-Guide.pdf>

ACT Parliamentary Counsel (2008). *Children and Young People Act 2008, R69*. Retrieved from: <https://www.legislation.act.gov.au/a/2008-19/current/pdf/2008-19.pdf>

Alati, R., Najman, J. M., Shuttlewood, G. J., Williams, G. M., & Bor, W. (2003). Changes in mental health status amongst children of migrants to Australia: A longitudinal study. *Sociology of Health and Illness, 25*(7), 866-888.

Australian Bureau of Statistics (ABS) (2015). *Disability, ageing and carers, Australia: Summary of findings, 2015 (Cat. No. 4430.0)*. Canberra: ABS. Retrieved from: <www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>

Australian Bureau of Statistics (ABS) (2012). *Information paper – A statistical definition of homelessness, 2012 (Cat. No. 4922.0).* Retrieved from: <www.abs.gov.au/ausstats/abs@.nsf/Lookup/4922.0main+features12012?opendocument>

Australian Human Rights Commission (AHRC) (2016). *Children's Rights Report 2016*. Retrieved from: <www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2016>

Australian Human Rights Commission (AHRC) (2017). *About children's rights*. Retrieved from: <www.humanrights.gov.au/our-work/childrens-rights/about-childrens-rights>

Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) (2011). *Improving the mental health of infants, children and adolescents in Australia: Position paper of the Australian Infant, Child, Adolescent and Family Mental Health Association Ltd.* Retrieved from: <http://bit.ly/2D71sdy>

Australian Institute of Family Studies (AIFS) (2013). *Evaluation and innovation in family support services (CFCA Practitioner Resource).* Melbourne: Australian Institute of Family Studies.

Benjet, C., Borges, G., Medina-Mora, M. E. (2010). Chronic childhood adversity and onset of psychopathology during three life stages: Childhood, adolescence and adulthood. *Journal of Psychiatric Research, 44*, 732-740.

Bennett, G., & Jessani, N. (2011). *The knowledge translation toolkit. Bridging the know-do gap: A resource for researchers.* India: Sage Publications.

Bornstein, M. (2013). Parenting and child mental health: a cross-cultural perspective. *World Psychiatry, 12*(3), 258–265.

Boscarino, J. A. (2004). Posttraumatic stress disorder and physical illness: Results from clinical and epidemiological studies. *Annals of the New York Academy of Sciences, 1032*, 141-53.

Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husen & N. Postlethwaite (Eds.), *International Encyclopedia of Education.* Oxford: Elsevier.

Burgermeister, D. (2007). Childhood adversity: A review of measurement instruments. *Journal of Nursing Measurement, 15*(3): 163-176.

Burton, M., Pavord, E., & Williams, B. (2014). *An introduction to child and adolescent mental health*. Los Angeles: Sage.

Butterworth, P., Leach, L. S., Pirkis, J., & Kelaher, M. (2012). Poor mental health influences risk and duration of unemployment: a prospective study. *Social Psychiatry and Psychiatric Epidemiology, 47*(6), 1013-21.

Canadian Institutes of Health Research. (2018). *Knowledge translation.* Retrieved from: <www.cihr-irsc.gc.ca/e/29529.html>

Commerford, J., & Hunter, C. (2017). *Principles for high quality playgroups: Examples from research and practice (CFCA Practitioner Resource)*. Melbourne: Australian Institute of Family Studies. Retrieved from: <www.aifs.gov.au/cfca/publications/principles-high-quality-playgroups>

Commonwealth Department of Health and Aged Care (2000). *Promotion, prevention and early intervention for mental health—A monograph*. Canberra: Mental Health and Special Programs Branch.

Council of Australian Governments (COAG) (2009). *Protecting children is everyone's business: National Framework for Protecting Australia's Children 2009-2020*. Retrieved from <https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/protecting-children-is-everyones-business>

Coyne, I. (2006). Consultation with children in hospital: Children, parents' and nurses' perspectives. *Journal of Clinical Nursing, 15*, 61-71.

Curran, G. M., Bauer, M., Mittman, B., Pyne, J. M., & Stetler, C. (2012). Effectiveness-implementation hybrid designs: Combining elements of clinical effectiveness and implementation research to enhance public health impact. *Medical Care, 50*(3), 217-226.

Department of Health (2015, March). Primary Health Networks (PHNs). Retrieved from: <www1.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks>

Department of Social Services (2017). *Family and children's services*. Retrieved from: <www.dss.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program/family-and-children-s-services>

Dogar, I. A. (2007). Biopsychosocial model. *Annals of Punjab Medical College, 1*(1), 11-13.

Dube, S. R., Felitti, V. J., Dong, M., Giles, W. H., & Anda, R. F. (2003). The impact of adverse childhood experiences on health problems: Evidence from four birth cohorts dating back to 1900. *Preventive Medicine. 37*, 268-77.

Egger, H. L., & Emde, R. N. (2011). Developmentally sensitive diagnostic criteria for mental health disorders in early childhood: The diagnostic and statistical manual of mental disorders—IV, the research diagnostic criteria—preschool age, and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood—Revised. *American Psychologist, 66*(2), 95-106.

Fazel, S., Doll, H., & Langstrom, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(9), 1010-19.

Fearon, R. M., & Belsky, J. (2004). Attachment and attention: Protection in relation to gender and cumulative social-contextual adversity. *Child Development, 75*, 1677-93.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Flaherty, E. G., Thompson, R., & Litrownik, A. J. (2009). Adverse childhood exposures and reported health at age 12. *Academic Pediatrics, 9*, 150-156.

Furber, G., Segal, L., Leach, M., Turnbull, C., Proctor, N., Diamond, M., Miller, S., & McGorry, P. (2015). Preventing mental illness: Closing the evidence-practice gap through workforce and services planning. *BMC Health Services Research, 15*, 283.

Georgiades, K., Paksarian, D., Rudolph, K E., & Merikangas, K. R. (2018). Prevalence of mental disorders and service use by immigration generation and race/ethnicity among U.S. adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 57*(4), 280-287.

Graham, I. D., 2012. Knowledge synthesis and the Canadian Institutes of Health Research. Systematic Reviews, 1(6). doi: 10.1186/2046-4053-1-6

Guy, S., Furber, G., Leach, M., & Segal, L. (2016). How many children in Australia are at risk of adult mental illness? *Australian and New Zealand Journal of Psychiatry, 50*(12), 1146-1160.

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services, 89*, 3-22.

Hawton, K., & van Heeringen, K. (2009). Suicide. *The Lancet, 373*(9672), 1372-81.

Head, B. (2011). Why not ask them? Mapping and promoting youth participation. *Children and Youth Services Review, 33*(4), 541-547.

Herman, J. (1992). *Trauma and recovery: From domestic abuse to political terror*. London: Pandora.

Herzig-Anderson, K., Colognori, D., Fox, J. K., Stewart, C. E., & Warner, C. M. (2012). School-based anxiety treatments for children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 21*, 655-668.

Hunter, C. (2012). *Is resilience still a useful concept when working with children and young people? (CFCA paper no. 2)*. Melbourne: Child Family Community Australia, Australian Institute of Family Studies. Retrieved from: <www.aifs.gov.au/cfca/publications/resilience-still-useful-concept-when-working-children-and-young-people>

Joukamaa, M. (2001). Mental disorders and cause-specific mortality. *British Journal of Psychiatry, 179*(6), 498-502.

Khan, A., & Francis, A. (2015). Strengths based practice with children with a mental health condition. *International Journal of Social Work and Human Services Practice, 3*(1), 9-19.

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(2), 339-352.

Kryg, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R. (2002). *World report on violence and health.* Geneva: WHO.

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley J., Zubrick, S. R. (2015). *The mental health of children & adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Canberra: Department of Health.

Merten, E. C., Cwik, J. C., Margraf, J., & Schneider, S. (2017). Overdiagnosis of mental disorders in children and adolescents (in developed countries). *Child and Adolescent Psychiatry and Mental Health, 11*(5).

Miles, J., Espiritu, R. C., Horen, N. M., Sebian, J., & Waetzig, E. (2010). *A public health approach to children's mental health: A conceptual framework*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Moore, T. (2017). *Protection through participation: Involving children in child-safe organisations (CFCA practitioner resource)*. Melbourne: Australian Institute of Family Studies. Retrieved from: <www.aifs.gov.au/cfca/publications/protection-through-participation>

Moore, T. G., Arefadib, N., Deery, A., Keyes, M., & West, S. (2017). *The First Thousand Days: An evidence paper – summary*. Parkville, Victoria: Centre for Community Child Health, Murdoch Children's Research Institute.

Moore, T., & McDonald, M. (2013). *Acting early, changing lives: How prevention and early action saves money and improves wellbeing*. Prepared for the Benevolent Society. Parkville, Victoria: The Murdoch Children's Research Institute, The Royal Children's Hospital.

Moore, T., McDonald, M., & McHugh-Dillon, H. (2014). *Early childhood development and the social determinants of health inequities: A review of the evidence*. Parkville, Victoria: Centre for Community Child Health at the Murdoch Childrens Research Institute and the Royal Melbourne Hospital.

Moore, T., McDonald, M., McHugh-Dillon, H., & West, S. (2016). *Community engagement: A key strategy for improving outcomes for Australian families (CFCA paper no. 39)*. Melbourne: Australian Institute of Family Studies. Retrieved from: <www.aifs.gov.au/cfca/publications/community-engagement>

Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington DC: National Academy Press.

National Aboriginal Community Controlled Health Organisation (2017). About NACCHO. Retrieved from: <www.naccho.org.au/about>

National Implementation Research Network (NIRN) (2015). *Implementation science defined*. Retrieved from: <https://nirn.fpg.unc.edu/learn-implementation/implementation-science-defined>

National Research Council and Institute of Medicine (2009). *Depression in parents, parenting, and children: Opportunities to improve identification, treatment, and prevention*. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. Retrieved from: <www.nap.edu/read/12565/chapter/1>

National Scientific Council on the Developing Child (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain: Working paper 12*. Retrieved from: <www.developingchild.harvard.edu/resources/the-science-of-neglect-the-persistent-absence-of-responsive-care-disrupts-the-developing-brain>

National Scientific Council on the Developing Child (2015). *Supportive relationships and active skill-building strengthen the foundations of resilience: Working paper no. 13*. Retrieved from: <www.developingchild.harvard.edu/resources/supportive-relationships-and-active-skill-building-strengthen-the-foundations-of-resilience/>

Parker, R. (2013). *Evaluation and innovation in family support services (CFCA practitioner resource)*. Melbourne: Australian Institute of Family Studies. Retrieved from: <www.aifs.gov.au/cfca/publications/evaluation-and-innovation-family-support-services>

Price-Robertson, R., Smart, D., & Bromfield, L. (2010). Family is for life: Connections between childhood family experiences and wellbeing in early adulthood. *Family Matters, 85*(1), 7–17.

Raphael, B., Stevens, G., & Pedersen, K. (2006). Vulnerability and mental health. *Vulnerable Children and Youth Studies, 1*, 127–138.

Schore, A. N. (2002). Dysregulation of the right brain: A fundamental mechanism of traumatic attachment and the psychopathogenesis of posttraumatic stress disorder. *Australian and New Zealand Journal of Psychiatry, 36*, 9–30.

Scott, D., Arney, F., & Vimpani, G. (2013). Think child, think family, think community. In F. Arney & D. Scott (Eds.), *Working with vulnerable families: A partnership approach*. Melbourne: Cambridge University Press.

Segal, L., Guy, S., & Furber, G. (2017). What is the current level of mental health service delivery and expenditure on infants, children, adolescents, and young people in Australia? *Australian and New Zealand Journal of Psychiatry, 52*(2): 163–172.

Sibley, K.M., & Salbach, N.M. (2015). *Applying knowledge translation theory to physical therapy research and practice in balance and gait assessment: Case report*. Physical Therapy, 95(4), 579–587.

Smart, J. (2017). *Risk and protective factors for child abuse and neglect (CFCA resource sheet)*. Melbourne: Australian Institute for Family Studies. Retrieved from: <www.aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect>

SNAICC (2012). *Healing in practice: Promising practices in healing programs for Aboriginal and Torres Strait Islander children and families*. Retrieved from: <www.snaicc.org.au/wp-content/uploads/2015/12/02926.pdf>

United Nations Human Rights Office of the High Commissioner (1990). *United Nations Convention on the Rights of the Child*. Retrieved from: <www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

University of Western Sydney (2016). Definitions of Aboriginal and Torres Strait Islander peoples. Retrieved from: <https://www.westernsydney.edu.au/oatsiee/aboriginal_and_torres_strait_islander_employment_and_engagement/workplace_relations/definitions_of_aboriginal_and_torres_strait_islander_people>

Usborne, E., & Taylor, D. M. (2010). The role of cultural identity clarity for self-concept clarity, self-esteem, and subjective well-being. *Personality and Social Psychology Bulletin, 36*(7), 883-897.

VicHealth (2015a). *Evidence review: Addressing the social determinants of inequities in mental wellbeing of children and adolescents*. Carlton South: VicHealth.

VicHealth (2015b). *Epidemiological evidence relating to resilience and young people: A literature review*. Melbourne: Victorian Health Promotion Foundation. Retrieved from: <www.vichealth.vic.gov.au/search/mental-wellbeing-strategy>

von Klitzing, K., Döhnert, M., Kroll, M., & Grube, M. (2015). Mental disorders in early childhood. *Dtsch Arztebl Int, 112*(21-22): 375-386.

Wilkinson, R., & Marmot, M. (2003). *Social determinants of health: The solid facts*. 2nd ed. Geneva: World Health Organization.

World Associaton for Infant Mental Health (2014). *WAIMH position paper on the rights of infants*. Retrieved from: <https://perspectives.waimh.org/wp-content/uploads/sites/9/2017/05/PositionPaperRightsInfants_-May_13_2016_1-2_Perspectives_IMH_corr.pdf>

World Health Organization (2018). *Mental health: strengthening our response (Fact Sheet)*. Retrieved from: <www.who.int/mediacentre/factsheets/fs220/en/>

World Health Organization (2018). *Social determinants of health*. Retrieved from: <www.who.int/social_determinants/en/>

Zeanah Jr, C. H., & Zeanah, P. D. (2009). The scope of infant mental health. In C. H. Zeanah Jnr, (Ed.), *Handbook of infant mental health* (pp. 5-21). New York: The Guildford Press.

Zubrick, S., Smith, G., Nicholson, J., Sanson, A., Jackiewicz, T., & the LSAC Research Consortium (2008). *Parenting and families in Australia (social policy research paper no. 34)*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs.

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