



The Royal
Australian &
New Zealand
College of
Psychiatrists



Faculty of Child and Adolescent Psychiatry
Section of Perinatal and Infant Psychiatry

Building mental health and
wellbeing in Australia and
New Zealand through early
support for infants, children
and their families



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Psychiatrists



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Executive summary

Key messages

Most adult mental health problems have their origins in childhood. The period from conception to age 5 years is critical for brain development and is the time when infants and children are most susceptible to environmental influences. This is an opportunity for establishing lifelong patterns of mental health and wellbeing.

There is a crucial need to identify children and families who need special support to maximise mental health and wellbeing. Preventing or reducing exposure to adverse childhood experiences (ACEs) could reduce the rate of common mental disorders in the population by an estimated 30%.

There is need to integrate support for infant and child mental health through a whole-of-system approach to provide the right care at the right time. Co-location of mental health services within other services that families routinely visit removes barriers to access and reduces stigma.

A mental health system requires a highly skilled collaborative workforce with well understood roles and effective intercommunication with a focus on prevention and early intervention, not just crisis management. Early psychiatric support is crucial for vulnerable infants and children.

Background

In New Zealand approximately 11% of children aged 3–4 years have emotional difficulties. [1] In Australia an estimated 16% of Australian children aged 2–3 years have social-emotional problems and almost 25% have behavioural problems.[2] These problems are more common among infants who are exposed to hostile or inattentive parenting, those whose primary caregiver had a probable serious mental health illness, or those in households living in severe poverty.[2]

The need to improve outcomes through prevention and early support strategies in the early years is well recognised by governments, via Aotearoa-New Zealand's [Well Child Tamariki Ora Programme](#) and Australia's [National Children's Mental Health](#)

[and Wellbeing Strategy](#).

However, services are currently inadequate to meet needs of families, infants and young children with, or at risk of, social and emotional difficulties or incipient mental health problems.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed this report *Building mental health and wellbeing in Australia and New Zealand through early support for infants, children and their families* focusing on children aged 0–12 years, with a particular focus on early childhood (the first 5 years). This report outlines key strategies to inform implementation of responsive, integrated, sustainable and equitable national plans to ensure children in the first five years of life are supported to be safe, healthy and ready to thrive.

Strategies to improve mental health outcomes for infants and children

Strategies for preventing and managing risks to early childhood mental health and wellbeing requires approaches to build resilience and prevent adverse effects of exposure to risk factors. The most effective approaches are family-focused, delivered via coordinated services, that incorporate prevention throughout the family structure, such as access to comprehensive antenatal and postnatal care, parenting support to encourage healthy attachment, sustained nurse home visiting programs to support disadvantaged families, high-quality child care and preschool curriculum.[3-5]

Screening and case identification

Pregnancy and early childhood are the time when parents are frequently in contact with health services, so it provides an ideal opportunity for screening and early intervention. To be effective, this must not be limited to screening or case-finding for anxiety and depression but must involve processes for identifying psychosocial risk factors that predict maternal mental health challenges and parenting difficulties. Screening/ case-finding and referral to appropriate support must continue beyond birth.

Novel digital platforms have been developed to identify child development, parental mental health and family psychosocial needs using opportunistic contacts such as vaccination and routine health care visits [6] that has been shown to be feasible and acceptable.[7]

Collaborative care models

Services are not currently fit for purpose as families find it extremely difficult to access and navigate them.

Collaborative care models that integrate multidisciplinary teams, including mental

health specialists, into primary care settings have shown benefits for the delivery of mental health care for children with depression, anxiety or behaviour problems.[5]

Maternity services should be designed for continuity of care throughout pregnancy and the 'fourth trimester'. There should be clear communication between all providers, and with explicit protocols for handover to primary care and child health for of vulnerable mothers and babies, so they can be referred to early intervention programs.

Whole of community approach

Integration includes how to address unmet social, early learning and health care needs (e.g., transport, poverty, food insecurity, affordability of health care, housing, etc.). It requires addressing barriers to not picking up children early, recognising and addressing why disadvantaged families are not using services, and ensuring that benefits are provided to those most in need.

Parents may face significant stigma when referred to mental health services with their infants and children. Public education is needed to overcome stigma associated with infant and child mental health care, just as it has been necessary to work hard over recent years to reduce stigma for adults with mental illness.

The role of the psychiatrist

Early psychiatric support is crucial for vulnerable infants and children. The involvement of psychiatrists enables effective mental health care to be integrated into children's care across the spectrum and to liaise effectively with other health professionals including GPs, nurses, paediatricians, psychologists and allied health in a non-stigmatising way.

[Perinatal, infant and early childhood mental health services](#) are central to the effective promotion of child mental health and wellbeing.[8] Strong links and collaboration are needed with general practice, child health services, family support services and adult mental health services, alcohol and other drug services, child protection services, services for children in care, and families who experience domestic and family violence.

Adult and addiction psychiatrists support women before they become pregnant to prioritise any future child's mental health and wellbeing when planning or avoiding pregnancy – as well as potential fathers – with the goal of safeguarding and fostering children's mental health and wellbeing. Links between alcohol and other drug services are important with referral pathways for early support.

There are too few psychiatrists in Australia and Aotearoa-New Zealand to cover the ever-increasing demand in the child mental health field. Workforce initiatives are urgently required to address this.

Broad skilled workforce focused on prevention and early support

A strong and coherent mental health system requires attention to infant and child mental wellbeing practised within roles and at all levels between providers of health, community services and education.

Current evidence supports investment in education and support of all health professionals working with parents and potential parents, to enable them to identify and manage mental health risks early, during a child's first 2000 days.[6] Key focus is on primary care, and the ability of early childhood education and care centres and schools to support children's social and emotional development.[9]

Key recommendations

Service provision

01 Develop coherent strategies with actionable implementation plans that is responsive, integrated, sustainable and equitable (RISE framework) for supporting children in the first five years of life to ensure they are safe, healthy and ready to thrive.[10]

02 Break cycles of poverty, inequality and intergenerational violence and disadvantage by addressing the social determinants and wrapping health care (child developmental and parental mental health needs) with early childhood education and social care through service coordination and navigation e.g. integrated continuum of connect and care including hubs.[11]

03 Focus on engagement and empowerment of families and communities to promote positive childhood experiences e.g. [Healthy Outcomes from Positive Experiences \(HOPE\)](#).

04 Embed screening or case-finding in a framework of well-functioning referral pathways and responsive services that are flexible and adaptive to needs of individuals, including hard-to-reach populations with high levels of multiple risk factors for psychosocial adversity and mental health problems (e.g. women with chronic mental illness, and women with history of trauma).

05 Co-locate mental health services within other services that families routinely visit to increase use of services by removing barriers to access and reducing the stigma. Use the strength of universal services to destigmatise and deliver prevention and early intervention services e.g. universal access to early developmental checks aligned with vaccination visits.[6]

06 Information, resource and capacity building through awareness and co-design with children, families and communities and through 'community of practice' with all professionals interacting with children to enhance coordinated, holistic and quality care delivery including children's quality of life through 'nurturing care' and play. [11]

07 Develop priorities and refine outcome indicators that are key to early years including for mental health and wellbeing in the perinatal and preschool years, informed by stakeholders including children, families and communities.

08 Ascertain through co-design with children and families what outcome variables at local, state and national level are critical and how to measure these over time.

09 Introduce, disseminate and maintain rigorously evaluated prevention and early intervention programs across all age-groups.

10 Implement continued strategies to reduce stigma associated with mental illness in infants and children including public education.

Research

11 Further research into effectiveness of prevention and early intervention programs for infants, children and adolescents in particular well-designed cohort studies to track the impact of ACEs, and trials of interventions to prevent them or reduce their impact should be global research priorities.[12]

12 Further research and evidence on implementation of an integrated service system for physical health and development, mental health, early learning and social care starting from identification of needs at population level to matching services via tiered care.

13 Research effectiveness of leveraging new initiatives such as child and family integrated hubs, head to health hubs, free access to parenting programs including blended service delivery and digital platforms.

14 Voice of children and families including those from priority groups (CALD, Indigenous, rural/remote etc) should be paramount in identifying areas that need adaptation / contextualisation and gaps in the evidence/data required to support them and how to fill these.

Workforce

15 Increase capacity and competence of the broader workforce to engage in prevention and early support for infants and children at risk families, and support for parents and caregivers' mental health and wellbeing.

16 Psychiatrists to adopt roles and responsibilities in a proactive manner aimed at reducing the prevalence of mental health problems and promoting good mental health in the early years.

17 Increase the psychiatry workforce as a matter of priority.[9, 13]



Introduction

Child mental health and wellbeing is properly understood within the context of psychosocial, family, social, cultural, and intergenerational factors.

The mental health and wellbeing of infants and children is important because it is the foundation for mental health in adolescence and adulthood. The period from conception to age 3 years is critical for brain development and is the time when infants are most susceptible to environmental influences. [14-16] This means it is not only a critical period for avoiding stressors, but a 'window of opportunity' for establishing lifelong patterns of mental health and wellbeing. To achieve these, children need a safe, secure and nurturing environment, with good nutrition and healthy mental stimulation by their parents or caregivers.[14]

Social-emotional and behavioural problems in infancy can be normal and resolve over time as the child matures cognitively and emotionally. For some children, however, problems become severe and persistent and may develop into later mental health problems.[15] The World Health Organization rates poor mental health among the biggest threats to early childhood development.[14]

Worldwide, it is estimated that over 13% of children and adolescents have a mental disorder, such as an anxiety disorder (approximately 7%), depressive disorder (approximately 2%), ADHD (approximately 3%) or a disruptive disorder (approximately 6%).[17]

In infants, disorders of attachment may manifest as failure to thrive, feeding problems and difficulty settling.

Children are not typically diagnosed with psychological disorders before the age of 2 years, but may show clinically significant and impairing social, emotional and behavioural problems such as anxiety, aggression, irritability, or oppositional behaviour beyond accepted age-appropriate norms.[15] Developmentally normal behaviours are generally distinguished from disorders only according to whether they are transient or persistent. Although the presence of 'normal' problem behaviours in infants and toddlers cannot be considered diagnostic in individuals, at a population level they are strongly associated with later emotional and behavioural problems.[15]

This report follows and builds on the Faculty of Child and Adolescent Psychiatry's 2010 report *Prevention and early intervention of mental illness in infants, children and adolescents*. [18] That report provided an overview of evidence on prevention and early intervention of mental illness in childhood, and recommended strategies for implementing effective interventions. It recommended that the roles of psychiatrists, particularly child and adolescent psychiatrists, be broadened to include the provision of leadership to multidisciplinary teams, training of other professionals, and advocacy for improvements in service delivery.[18]

Since the 2010 report there have been advances in research, policy and practice for the identification and early intervention of mental illness in infants and children. The large and constantly increasing volume of literature on early intervention – covering clinical practice, service delivery models and policy settings – makes it challenging for psychiatrists to remain up to date on this important field. This report summarises current clinical literature and policy developments.

Purpose of this report

The overall aim of this report is to promote the mental health of infants and young children in Australia and Aotearoa-New Zealand, as a foundation for lifelong mental health.

This report is intended to:

- provide an update on current understanding of the associations between risk factors and mental health problems/psychiatric disorders in infants and children
- identify how risk factors can be detected and managed in infants and young children
- identify opportunities for prevention and early intervention in Australia and Aotearoa-New Zealand
- summarise current evidence for the effectiveness of strategies for the prevention and early management of mental health problems in children
- identify optimal roles for child and adolescent psychiatrists, and for perinatal and infant psychiatrists
- outline a framework for integrating early intervention into health care in Australian and Aotearoa-New Zealand across healthcare system levels and across agencies and settings
- identify areas in which further research is needed to inform clinical care and delivery
- make recommendations for improving early intervention in Australia and Aotearoa-New Zealand.

Who should read this report?

This report is intended for:

- psychiatrists, including RANZCP Faculty of Child and Adolescent Psychiatry (FCAP) members, RANZCP Section of Perinatal and Infant Psychiatry (SPIP) members, adult psychiatrists who treat patients who are parents or future parents, and other RANZCP members
- other health professionals
- health educators
- health system policy makers.
- Although this report contains information and recommendation of interest to the Australian and Aotearoa-New Zealand public, it is not intended for healthcare consumers. Information for people with mental health problems and their families is available on the [RANZCP website](#).

Scope

- This report covers how policy and practice might enhance and protect children's mental health and wellbeing, and how we might better help young children who are experiencing challenges to their mental health, or are struggling or unwell. It is not intended as a clinical practice guideline on treatments for children with established psychiatric diagnoses.
- It includes children aged 0–12 years, with a focus on early childhood (the first 5 years).
- The recommendations in this report are for Australia and Aotearoa-New Zealand.

Note on the evidence

There is considerable overlap between these categories within the body of evidence on the effects of childhood mental health prevention and early

intervention strategies. For example, antenatal education and support programs, home visiting programs and parenting programs may share aims and content, yet are often separated in systematic reviews selecting interventions based on setting. Within categories, there is also considerable heterogeneity in the content of interventions and the outcomes measured.

This report attempts to summarise benefits reported in systematic reviews according to target group, setting, and components of the intervention, although it is recognised that consistent approaches have not been used, and the evidence in this area is constantly evolving. Psychiatrists or services looking to implement specific programs to support children and families should review available updated evidence where available.

Definitions

In this report, prevention and early intervention are defined as any actions aimed at identifying and/or treating risk factors for, or early symptoms of, emotional and behavioural disturbance that may lead to mental illness in childhood or adolescence.

Mental health problem: the presence of social-emotional or behavioural symptoms or signs, which may include undiagnosed mental health disorders or subsyndromal pathology

Mental health disorder (mental illness): a persisting pattern of symptoms or signs that meet criteria for a specific diagnosis

Risk factors: factors (including environments and experiences) associated, at the population level, with increased

risk of developing a mental health problem or mental disorder. Risk factors are not necessarily causal and are not determinative.

Attachment theory: the process by which children during early life learn to use their parents as a secure base to explore their environment.

Prevention: actions aimed to maintain positive mental health by pre-emptively addressing factors that may lead to mental health problems or illnesses. These strategies can be aimed at increasing protective factors, decreasing risk factors or both.

Early intervention: early treatment or actions aimed to prevent progression or reduce impact of or resolve mental

health problems or illnesses promptly, after identification of early manifestations. Treatment of mental health problems in childhood and adolescence can be a form of early intervention to prevent mental illness in early adulthood.

Universal preventive interventions: interventions targeting entire populations. These can include or overlap with mental health promotion strategies.

Targeted or selective interventions: activities directed at groups identified as having increased risk of developing mental health problem. Targeted intervention can overlap with early intervention because recipients can include those with minimal but detectable signs and symptoms foreshadowing mental disorder or mental health problems.

01.

What supports or disrupts children's mental health and wellbeing?

The developing child's mental health is supported by a close nurturing relationship with parents,* safe and positive play and communication between parents and infants, sensitive and responsive parenting, social support for the child's family, support for parents' mental health, and protection from maltreatment.

Factors associated with mental health and wellbeing include:

- strong and supportive family/whānau relationships
- strong and supportive friendships
- feeling accepted, valued and respected
- connection to one's culture and cultural identity
- healthy natural environments
- living in a family/whānau whose basic needs, such as food and housing, are met
- safe and community-oriented schools
- supportive and engaging teachers.

Early life experiences predict or influence a range of cognitive and health outcomes throughout life, including mental health and the risks of drug and alcohol misuse, violent and antisocial behaviour, and even memory loss in older age.[4]

A range of environmental risk factors for mental health problems (Table 1) has been identified, in addition to genetic disposition, temperament, and epigenetic transmissions from parents and grandparents. Multiple risk factors may compound in ways that are not yet fully understood. Intergenerational mental illness is not only due to heritable biological traits, but reflects the intersection of social determinants of mental health and early vulnerability (e.g. family violence, placement in care other than immediate family/whānau, and multiple trauma).

The effects of exposure to risk factors may be reduced or offset by protective factors that foster resilience, such as a close and positive bond between caregivers and infants and emotional sensitivity and responsiveness of parents.[19] Children's wellbeing is supported by protective factors like involvement of fathers in their children's care, positive communication and play between caregivers and children, socioeconomic security and equality for families, social and emotional support for parents, and strong communities supporting families, support for parents and caregivers' mental health and wellbeing.[14]

Section 4 Strategies for preventing and managing risks to early childhood mental health and wellbeing discusses approaches

to building resilience and preventing adverse effects of exposure to risk factors. Effective approaches are frequently family-focused, delivered via coordinated services, which incorporate prevention throughout the family structure.

Aotearoa-New Zealand Office of the Children's Commissioner working definition of child wellbeing [20]

Wellbeing is a positive state and not simply the absence of negatives. Children experience wellbeing when their family and whānau are connected and united; relationships within and beyond the family and whānau are thriving; family and whānau members support each other; there are opportunities for individual and collective growth; and all members of their family and whānau have their needs met. A community has achieved child wellbeing when all children and their whānau have their rights fulfilled and the conditions are in place to enable all children to participate in society and plan, develop and achieve meaningful lives.

* 'Parents' refers to primary caregivers assuming a parenting role

Environmental exposures associated with increased risk of mental health problems in infants and children

In utero exposure to alcohol and other drugs

Maternal stress during pregnancy

Disorganised attachment

Maladaptive parenting practices

Maltreatment (e.g. abuse or neglect)

Family violence

Distressing childhood experiences

Parental conflict

Parental stress

Parental separation or divorce

Parental mental illness

Socioeconomic disadvantage

Inadequate housing

Table 1. Environmental exposures associated with increased risk of mental health problems in infants and children [3, 21-25]

Summary of evidence for risk factors

The effects of stressors on infant and child development wellbeing are best understood and described within a resilience framework, where discussion of toxic stress is always accompanied by an explanation of people's capacity for resilience. This approach avoids the unhelpful belief that damage from adverse experiences in childhood is irreversible, and avoids unhelpful parental guilt.[26]

In utero exposures

The gestational environment may affect later health. Maternal stress during pregnancy has been associated with increased risk of adverse behavioural and emotional outcomes in children.[27] In some studies, symptoms of anxiety and depression in pregnant women have been associated with increased risk of a mental disorder in the child.[27] However, the effects of prenatal stress on child development are inconsistent and cannot be predicted, likely due to interactions between genes and the child's environment.[27]

Increases in externalising and internalising problems, poorer cognitive outcomes and structural brain changes at age 6–7 years have been observed among Aotearoa-New Zealand children exposed to methamphetamine during gestation.[28]

Early childhood stress

Frequent, intensive and persistent activation of stress responses during early childhood has been associated with range of mental health problems as well as stress-related diseases of adulthood, such as cardiovascular disease, obesity, and type 2 diabetes.[29] The influence of stress responses on central nervous system development is thought to be one of the mechanisms through which exposure to violence, maltreatment or other adverse experiences leads to mental health problems.[29, 30]

Among children already exposed to trauma, poor mental health outcomes are not inevitable.[29] Interventions for infants and young children in foster care, or identified by child protection services, have been shown to significantly improve biological markers of stress including markers of hypothalamic–pituitary–adrenal axis functioning, central nervous system markers, and epigenetic markers.[30] For example, earlier foster care placement has been found to improve stress responses.[30] For those exposed to violence, factors that protect against poor outcomes include family support, school support, and peer support.[31]

Poor parenting/ caregiving and maltreatment

The quality of the infant's first relationship with a parent or caregiver can promote or prevent emotional development, which can influence later health and personality. Adverse childhood experiences that are strongly associated with poor mental health throughout life include maltreatment, maladaptive parenting practices (such as harsh discipline, aversiveness, over-involvement or parent-child conflict), family dysfunction, violence and socioeconomic adversity.[25, 32]

Parental conflict and marital distress, as well as irritable or hostile parenting, are strong determinants of child mental health.[22] Among Australian children, family psychosocial factors appear to be stronger predictors of childhood mental health than socioeconomic factors.[22]

Children's degree of exposure to abuse and neglect is strongly associated with their risk of cognitive and language difficulties, becoming victims or perpetrators of violence in later life, or developing depression, anxiety, eating disorders, and

suicide – as well as a range of other social problems and chronic diseases.[16]

Risk factors for child maltreatment by parents or caregivers are mainly the same as those for mental illness. They include poor parent–child relationships and bonding, socioeconomic disadvantage and poverty, household overcrowding and inadequate housing, parental lack of understanding of children's needs, child development, or parenting skills, normalisation of violence against children or tolerance for it, parental anger management problems, parental stress or poor mental health, lack of access to or interaction with social support systems, parental history of abuse or neglect in their own family, and parental substance abuse.[5]

Parental mental illness and substance use problems

The presence of parental mental disorders is a strong risk factor for mental disorders.[33] Children of parents with mental illness have an increased risk of adverse developmental outcomes and mental health problems. Parental depression is a strong risk factor for developing depression.[34]

Most research has focused on mothers, though early paternal depression is also a significant predictor of a range of poorer child outcomes.[35] Maternal mental disorders can significantly affect children's psychosocial and psychological development.[36] The degree of risk is thought to be mediated by the quality of the mother–infant relationship [36].

Problem drug and alcohol use by parents or caregivers is associated with psychosocial and behavioural problems in children.[37] Parental drug and alcohol use disorders considerably increase the risk of poor mental health outcomes for children.[19, 38]

The impact of parental mental illness on the mental health of the child is determined by a complex interplay of genetic and environmental factors. This includes the age of the child, the nature of the parent's mental illness, the involvement of other adults in the child's life, and family/whānau relationships.[19] The emotional sensitivity and responsiveness of a parent is a key factor modulating mental health outcomes for the child.[19]

Among children of parents with drug and alcohol use disorders, a range of family, parental, child-related, or social and biological factors appear to protect children against developing psychological and social problems.[38] These include family cohesion and adaptability, secure parent-child attachment, and social and emotional support for parents.[38]

Socioeconomic deprivation

Globally, poverty is consistently associated with higher rates of mental illness and the lowest levels of wellbeing in children.[5, 22] In Australia, rates of child and adolescent antisocial behaviour are significantly higher among disadvantaged communities.[3]

Exposure to community disorganisation or peer antisocial involvement (indicators of community disadvantage) at age 4–8 years predicts adolescent violent behaviour.[3] Residential instability and poor living conditions have been associated with small increases in internalising and externalising behaviours among Australian children and adolescents.[23] Australian data also show a linear relationship between geographical remoteness and rates of mental illness and poor social and emotional functioning in children.[22]

A longitudinal cohort study in Aotearoa-New Zealand found that a greater proportion of children living in high-

deprivation areas (8%) reported their own health as poor, compared with 5% in medium- and low-deprivation areas. Children who experienced high deprivation in both infancy and pre-school to middle childhood were more likely than their peers to be experiencing depressive and anxiety symptoms at age 8.[39]

However, current rates of emotional and/or behavioural problems (diagnosed depression, anxiety disorder or attention-deficit hyperactive disorder [ADHD]) among Aotearoa-New Zealand children aged 2–14 years do not differ according to levels of neighbourhood deprivation.[40]

Interactions between risk factors

The presence of single risk factors does not predict outcomes in individuals. For example, a child's temperament and genetic disposition might regulate the effects of parenting styles, trauma, abuse or neglect.[16]

There are various hypotheses to explain why mental health outcomes vary among children exposed to similar risk factors. Mental illness may emerge from cumulative and interactive effects of exposure to multiple risk factors over the life course.[25] The early life environment may shape the child's coping strategies, affecting their resilience to later exposure to similar stressors.[41] Resilience or vulnerability in an individual might further depend on the combination of genetics, early-life environment and later-life environment.[42]

Infants and children in disadvantaged communities are exposed to clusters of risk factors like stress, poor physical and social development, and unsafe homes.[3] Accumulating evidence from many studies is contributing to emerging understanding of the direct and indirect associations between social determinants and health,

the pathways between them, and the biological mechanisms involved.[21]

Vulnerable groups

Children in care (children/tamariki up to the age of 18 who cannot live with their immediate family/whānau; care includes kinship care, foster care and residential care) show higher rates of mental health problems, including behavioural problem, than children in the general population.[43] They may show complex psychopathology, characterised by attachment difficulties, relationship insecurity, trauma-related anxiety, behavioural problems and inattention/hyperactivity.[44] (For more information, [refer to the RANZCP position statement on the mental health care needs of children in care or at risk of entering care.](#))

Australian Indigenous children experience challenges associated with multigenerational trauma, discrimination and socioeconomic deprivation. Poorer wellbeing and higher rates of mental illness have been reported among Australian Aboriginal and Torres Strait Islander children, compared with the general population.[22] Aboriginal and Torres Strait Islander are over-represented among children in care.

Tamariki Māori aged 2–14 years show significantly higher rates of depression than non-Māori.[40] A disproportionate number of rangatahi and tamariki Māori live in care, compared with other population groups.[45, 46]

Refugee children around the world show higher rates of psychological morbidity than children in the general population, especially post-traumatic stress disorder (PTSD), depression, and anxiety disorders.[47]

02.

Children's mental health and wellbeing in Australia

An estimated 16% of Australian children aged 2–3 years have social-emotional problems and almost 25% have behavioural problems. Almost 14% of children and adolescents aged 4–17 have experienced a mental health disorder within the past year.

Child abuse and neglect is the risk factor responsible for the greatest burden of disease for anxiety disorders, depressive disorders and suicide/self-inflicted injuries among children aged 5–14 years.

An estimated 21–23% Australian children have a parent with mental illness.

A higher proportion of Aboriginal and Torres Strait Islander children than non-Indigenous children are in care (e.g. kinship care, foster care or residential care).

Childhood mental health care services in Australia do not currently meet the needs of infants and young children with, or at risk of, social and emotional difficulties or incipient mental health problems.

Population, environment and health system in Australia

Australia's population is aging. The proportion of children aged 0–14 years decreased between 1999 and 2019, from 20.9% to 18.7% of the total population. Children aged 0–4 years make up approximately 3% of the population.[48]

The Australian Indigenous population is comparatively young, compared with the total Australian population. In 2021, a projected 32% of Indigenous Australians are aged under 15 (compared with 18% of non-Indigenous Australians). Children aged 0–4 years make up approximately 11% of Indigenous Australians.[49]

Australian child and family health services reflect the complex structure of Australian health services, which involve federal, state/territory and local governments, non-government organisations (NGOs), Aboriginal Community Controlled Health Organisations (ACCHOs) and private sector providers. Each jurisdiction is responsible for the provision of universal maternal, child and family health services. The way in which these services are funded and delivered varies across Australia.[50]

Public antenatal care is provided mainly by midwives working in state/territory government-funded organisations, through hospital clinics or in community-based settings. Many ACCHOs provide antenatal care through midwives, Aboriginal and/or Torres Strait Islander health workers or Aboriginal and/or Torres Strait Islander health practitioners (ATSIHPs). Antenatal care is also provided by GPs (often through shared care arrangements with local hospitals), and by private obstetricians.[50]

Mental health care for children is provided through general practices, ACCHOs, community mental health services, public mental health services (e.g. hospital-based outpatient clinics), school-based health services, private psychology practices and private psychiatry practices.

Australia's mental health system focuses on specialist intervention rather than prevention and early intervention, and on adults and adolescents rather than children. There is no system of affordable, integrated mental health care for children under 12 years.[51] Access to services varies between regions.

Summary of reported data

Social-emotional and behavioural problems in infants

An estimated 16% of Australian children aged 2–3 years have social-emotional problems and almost 25% have behavioural problems.[2] These problems are more common among infants whose caregiver only rarely or sometimes showed affection, warmth, or engaged in activities with their child, those exposed to hostile parenting incidents, those whose primary caregiver had a probable serious mental health illness, or those in households living in severe poverty.[2]

Mental health problem among children and adolescents

The most recent and comprehensive available national data, from the 2013–14 Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter survey), suggest that almost 14% of children and adolescents aged 4–17 experienced a mental health disorder in the previous 12 months.[52, 53] The most common disorders were ADHD (approximately 7%) and anxiety disorders (approximately 7%), major depressive disorder (approximately 3%) and conduct disorders (approximately 2%).[53] Approximately 4% of children and adolescents experienced more than one disorder.[53] Mental disorders were assessed as moderate or severe in about 15% of cases (6% of all children and adolescents).[53] Approximately 1% of children aged 4–11 years had a severe mental disorder.[53]

Rates of anxiety disorders were higher among children in families with lower

incomes and family functioning assessed as poor.[53] Over half (58%) of children aged 4–11 years with an anxiety disorder had missed at least one day of school in the previous 12 months due to anxiety symptoms.[53] Rates of anxiety diagnoses among children have increased in Australia in recent years, possibly partly due to higher rates of presentation to health services.[53]

Another Australian study analysing data from the Longitudinal Study of Australian Children estimated that approximately 8–10% of children aged 4–13 years had psychological problems in the clinical range, based on scores for the Strengths and Difficulties Questionnaire.[25]

Among participants in the 2013–14 Australian Child and Adolescent Survey of Mental Health and Wellbeing, 17% of children and adolescents aged 4–17 years had used services for emotional or behavioural problems in the previous 12 months, mainly health services.[53] Over half (56%) of those with mental disorders had used services, most commonly a GP, followed by a psychologist, paediatrician, counsellor or family therapist. Of those having mental disorders, around 3% had used specialist child and adolescent mental health services in the previous 12 months.[53]

Among those whose parents and carers reported that their child or adolescent needed help for emotional or behavioural problems in the previous 12 months (almost 27% of participants), less than half (approximately 43%) had their needs fully met.[53] Of those assessed as having a mental disorder, approximately 79% were reported to have needed help in the previous 12 months. Of these, 26% did not have their needs even partially met.[53] There is a significant lack of mental health inpatient beds for children and

adolescents in some Australian states and territories, and a severe lack of psychiatrists for children and adolescents.[9]

Prevalence and effects of risk factors

An Australian study based on data from the Longitudinal Study of Australian Children estimated that over half of infants had more than one risk factors for adult mental illness, such as being born to a mother who used alcohol daily (approximately 10%) or in a family where parents had separated (approximately 10%).[25] By age 8–9 years, more than 18% of children were exposed to five or more risk factors. At age 12–13 years, two-thirds had parents who displayed low warmth or exhibited high hostility/anger. Risks from negative parenting behaviours were highly prevalent across age groups.[25] The study estimated that one in seven children were in families exposed to three or more major life stressors.[25]

Another study analysed data from a large nationally representative sample of Australian children (the Australian Early Development Census) to identify groups with early childhood developmental vulnerabilities (thought to represent risk of later mental disorders) at the time of school entry. These risks were higher among children with backgrounds of child maltreatment, parental history of mental illness, parental history of criminal offending, socioeconomic disadvantage and perinatal adversity.[54] Overall, by the start of school, an estimated one in five children in Australia is considered developmentally vulnerable on at least one of the domains of physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication and general knowledge. [2, 55]



Abuse and neglect

The Australian Institute of Health and Welfare found that child abuse and neglect was the risk factor responsible for the greatest burden of disease for anxiety disorders, depressive disorders and suicide/self-inflicted injuries among children aged 5–14 years, and among girls and women well into middle adulthood.[21] It estimated that child abuse and neglect accounted for approximately 8% of the disease burden for girls and young women aged 15–24 years, almost 7% for women aged 25–44 years, and approximately 5% of the disease burden for boys and men up to age 44 years.[21]

Children in care

Almost 7% of Australian children aged 0–4 years are in care outside their immediate family (including kinship care, foster care and residential care).[2] Aboriginal and Torres Strait Islander children are approximately 10 times more likely to be in care than non-Indigenous children.[45] In Western Australia, an Aboriginal child is more than 19 times more likely to be placed in care than a non-Indigenous child.[2]

A Western Australian study found that Aboriginal children whose carers had been forcibly separated from their natural family (members of the 'stolen generation') were more than twice as likely to be at high risk of clinically significant emotional or behavioural difficulties than other children.[2]

Parental mental illness

Having a parent with a mental disorder is a strong risk factor for mental disorders in children.[33] An estimated 21–23% Australian children have a parent with mental illness.[19] However, accurate data are not available because adult mental health service providers have not routinely recorded whether their clients have children. Similarly, child and adolescent mental health services have not routinely recorded whether their clients have parents with a mental illness.[19]

The presence of perinatal mental health problems is a risk factor for adverse long-term social, emotional and behavioural development outcomes in children, especially when in combination with other stressors.[56] Studies in Australia and around the world have reported that up to one in 10 women experiences depression during pregnancy and one in seven women in the year following birth. Approximately one in five women experiences antenatal or postnatal anxiety disorder, often comorbid with depression.[57] Symptoms of schizophrenia, bipolar disorder and borderline personality disorder are less common during the perinatal period,[57] but can disrupt attachment between the mother and her baby. Severe mental illnesses are also commonly comorbid with alcohol and other drug problems, or associated with social adversity and trauma.

See RANZCP position statement [Perinatal mental health services](#). [8]

The impact of parental mental illness beyond the perinatal period and throughout childhood, is also important to recognise. See RANZCP position statement [Children of parents with mental illness](#). [7]

Are our mental healthcare services adequate to support infants and young children?

Childhood mental health care services in Australia do not currently meet the needs of infants and young children with, or at risk of, social and emotional difficulties or incipient mental health problems.

Australian studies have highlighted gaps in infant and early childhood mental health care. A 2020 information paper reported that most young children with social, emotional and behavioural difficulties do not receive professional help.[15] A study comparing health administrative records for 2014–2015 with the estimated prevalence of risk factors for mental illness found that children aged 0–4 years were underserved by the Australian mental health system relative to need.[58] It concluded that 'mental health service capacity needs to be several times larger to address need in children and adolescents'.[58] Another Australian study, which analysed data for children aged 6–17 years from the 2013–2014 national Child and Adolescent Survey of Mental Health and Wellbeing, estimated that less than 12% of those with mental disorders had sufficient contact with health professionals to receive minimally adequate treatment.[59] The authors suggested

that lack of adequate treatment may be contributing to the unchanging high prevalence of childhood mental disorders in Australia.[59]

A study based on the national survey dataset found that specialist child and adolescent mental health services were used by only 3.3% of 4–17 year-olds experiencing mental disorders in the previous 12 months.[53] The findings of a study analysing patterns of mental health care for children and adolescents in Australia between 1998 and 2014 suggested that the proportion of those with unmet need had decreased, but the gap in receiving sufficient care may have widened.[60] The authors reported that significant barriers to access remained despite investments in community awareness and treatment during the early 2000s.[60]

When children do access health care for mental health problems, they may not receive optimal quality care. An Australian study reported significant gaps between clinical practice guideline recommendations and actual care provided for children with depression and/or anxiety aged 15 years and under, particularly for assessments conducted in general practice.[61]

The Australian Productivity Commission's 2020 report on mental health identified underinvestment in prevention and early

intervention delivered early in life.[9] The report noted that barriers to psychiatric care for children and adolescents include high costs, long waiting times in some regions, and an overall lack of psychiatrists.[9]

We currently have a mental health system that focuses on intervention rather than prevention and early intervention, and on adults and adolescents rather than children. **In fact, for children under 12 years of age, there is no real 'system' of affordable, integrated care, delivered on the basis of need.** Instead, there is a fragmented assortment of programs, service offerings, inconsistent sources of resources (that are not necessarily evidence-based), siloed professionals in private practice, alongside inequity in access due to a family's geographical and financial circumstances. There is a lack of specialist workforce to meet the needs of children and families.

Source: The National Children's Mental Health and Wellbeing Strategy [51]

03.

Children's mental health and wellbeing in Aotearoa-New Zealand

Among children aged 0–14 years, approximately 5.7% have emotional and/or behavioural problems. Among those aged 2–14 years, 0.7% are diagnosed with depression and 3.7% with anxiety disorder, based on 2020–2021 survey data.[62]

Rates of emotional and/or behavioural problems, depression and anxiety in the 0–14 years age group are reported as slightly lower among tamariki Māori and Pacific than the national rate.[62]

A disproportionate number of rangatahi and tamariki Māori live in care outside their immediate family/whāna, compared with other population groups. In New Zealand in 2019, 69% of the children in Oranga Tamariki care identified as Māori.[45]

Suicide rates among rangatahi Māori aged 10–24 years are higher than among non-Māori, non-Pacific: twice as high among males and four times as high among females.[63]

Perinatal depression and anxiety are also common among women in Aotearoa New Zealand, particularly for Māori and Pacific women.

Population, environment and health system in Aotearoa New Zealand

The Māori population, which represents approximately 16% of the Aotearoa New Zealand population, is younger overall than the non-Māori population.[64] Children aged 0–4 make up approximately 12% of the total Māori population.[64] In 2018, 33.7% of Māori were younger less than 15 years, compared with only 18.0% of non-Māori.[64]

There are more than 40 different Pacific ethnic groups in Aotearoa New Zealand, each with its own culture, language, and history. In total, Pasifika make up 7.4% of the total Aotearoa New Zealand population. [65] Children aged 0–14 years made up approximately 36% of the Pasifika population in 2013, compared with

approximately 20% of the total Aotearoa-New Zealand population. [66]

Mental health services in the community are accessed mainly through referral from general practitioners. There is a lack of infant and early childhood mental health services. Mental health services for children under 12 years and early childhood mental healthcare is provided through general practices, community mental health services, public mental health services, school-based health services, and child and adolescent mental health services.

Prenatal and maternity care is provided through free public maternity services, mainly primary maternity services delivered in the community by lead maternity carers (midwives, general practitioners or obstetricians).[67]

Context

In Aotearoa, child mental health is primarily understood within the context of psychosocial, family, social, cultural, and intergenerational factors.

The wellbeing of tamariki Māori is inextricable from the wellbeing of their whānau.[68]

Approaches that align with Te Tiriti o Waitangi (the Treaty of Waitangi) and te ao Māori (the Māori world) are increasingly recognised and becoming embedded in the mainstream. Aspects of te ao Māori approaches include:

- strengths-based (rather than deficit-focused) framing and approaches

- recognition that tamariki cannot be understood and cannot thrive in isolation from their whānau.

The Te Taonga o Taku Ngākau: Ancestral knowledge and the wellbeing of Tamariki Māori report states: *There are numerous studies that highlight the range of negative indices experienced by whānau Māori ... Within dominant research, however, it is not always made clear that these negative indices have their roots in a long colonial history burdened with land theft, urbanisation, destruction of collectivity, and the marginalisation of traditional knowledges. Instead whānau are pathologised, made the problem and not the solution, or in the case of mental wellbeing and children, whānau are often left out of the discussion and decision making all together. The social and*

economic positioning of Māori whānau as a result of historical and ongoing colonialism further affects the capacity of Māori whānau to thrive and impacts on the mental health and wellbeing of tamariki.[69]

Māori have been disadvantaged through the process of colonisation, causing disconnection from land, culture, language, and whānau, hapū and iwi relationships. In the 1970s and 1980s, a large number of tamariki Māori were removed from whānau and placed in state care, and many experienced sexual, physical, and emotional abuse and neglect. Māori continue to be overrepresented in state care, which has been linked to ongoing breaches of Te Tiriti o Waitangi.

See RANZCP Position Statement: [Recognising the significance of Te Tiriti o Waitangi](#)

Summary of reported data

Social-emotional and behavioural problems in infants and pre-school children

The New Zealand Health Survey for 2018–2019 reported that almost 1% of infants aged 2–4 years had one or more doctor-diagnosed emotional and/or behavioural problem, including approximately 0.5% with diagnosed anxiety disorders and almost 0.5% with ADHD.[40] Another 1% had autism spectrum disorder.[40] In the 2020–2021 data, indicators are not reported by age group.

Strengths and Difficulties Questionnaire data collected by previous New Zealand Health Surveys suggest that approximately 11% of children aged 3–4 years have emotional difficulties, 14% have peer problems, 7% show hyperactivity and 10% show conduct problems.[1]

Mental health problem among children and adolescents

Approximately 6% of children aged 2–14 years has a doctor-diagnosed emotional and/or behavioural problem (diagnosed

depression, anxiety disorder and/or ADHD), based on data from the New Zealand Health Survey for 2020–2021.[62]

The prevalence of diagnosed depression among children aged 2–14 years is less than 1%. The rate is slightly lower among Māori (0.4%) and Pacific (0.5%).[62]

The prevalence of diagnosed anxiety disorder among children aged 2–14 years is approximately 4%. Rates are slightly lower among Māori (3.3%) Pacific (2.5%).[62]

Analysis of data from the Strengths and Difficulties Questionnaire collected in New Zealand Health Surveys results in higher estimates of social-emotional and behavioural problems, compared with rates of doctor-diagnosed disorders. A 2018 report found that among children aged 5–9 years, approximately 8% had emotional difficulties, 13% had peer problems, 8% showed hyperactivity and 10% showed conduct problems.[1] Among those aged 10–14, approximately 11% had emotional difficulties, 14% had peer problems, 9% showed hyperactivity and 10% showed conduct problems.[1]

Risk factors

Parental mental illness

Having a parent with a mental disorder is a strong risk factor for mental disorders in children.[33] An estimated 15–20% of Aotearoa-New Zealanders have a parent with mental illness.[19]

The presence of perinatal mental health problems is a risk factor for adverse long-term social, emotional and behavioural development outcomes in children, especially when in combination with other stressors.[56]

Studies around the world have reported that up to one in 10 women experiences depression during pregnancy and one in seven women in the year following birth. Approximately one in five women experiences antenatal or postnatal anxiety disorder, often comorbid with depression.[57]

Perinatal depression and anxiety are also common among women in Aotearoa-New Zealand, particularly for Māori and Pacific women.[56]

See RANZCP position statement [Perinatal mental health services](#). [8]

Are our mental healthcare services adequate to support infants and young children?

A recent report prepared for Aotearoa-New Zealand's Well Child Tamariki Ora Programme[70] noted a severe lack of infant and early childhood mental health services. The authors called for more infant and early childhood mental health services with up-to-date training of staff and a referral pathway tailored to the interventions available in each area, to ensure that all children receive appropriate interventions before developing significant difficulties and disorders.[70]

04.

Strategies for preventing and managing risks to early childhood mental health and wellbeing

Preventing or reducing exposure to adverse childhood experiences could reduce the rate of common mental disorders in the population by an estimated 30%. [32] Recent expert reports, including those prepared for Australian and Aotearoa-New Zealand governments, strongly argue that interventions during infancy are likely to have the greatest effects on children's mental wellbeing in later life. [3, 5, 16, 29]

Implementing strategies that target risk and protective factors in infancy and childhood may help reduce substance abuse, mental illness and antisocial behaviour. [3] Such strategies include health service organisation to promote public health and

provide targeted medical interventions designed to address biological and genetic risk factors, access to comprehensive antenatal care, parenting programs to encourage healthy attachment, sustained nurse home visiting programs to support disadvantaged families, high-quality child care, and preschool curriculum. [3-5]

There is consistent population-level evidence that interventions targeting adverse childhood experiences (ACEs) can reduce rates of common mental disorders and suicidality. [32] A recent systematic review found that routine clinical screening for ACEs is not indicated. [71] In this regard, it is noteworthy that even when individuals have experienced significant adverse experiences, programs that buffer ACEs using Positive Childhood Experiences (PCEs) can protect adult mental health. [72] In this regard, Healthy Outcomes from Positive Experiences (HOPE) framework can be used to build family connections and community resilience in order to improve outcomes. [73]

The WHO 'Nurturing care' framework for promoting early childhood development [14] emphasises services and interventions to support responsive caregiving through:

- national policies such as paid parental leave for both parents to support bonding between mother and child, breastfeeding, and involvement of fathers in their children's care, preventive health care, affordable, good-quality day care, child-friendly spaces in cities to promote play between caregivers and children, and education
- services and interventions to support attachment, encourage play and communication between caregivers and infants, promote caregiver sensitive and responsive parenting, support the involvement of fathers in caregiving, and provide social support
- support for caregivers' mental health
- prevention of child maltreatment.

Specific prevention and early intervention strategies implemented in Australia and Aotearoa-New Zealand are included in the 'summary of evidence' section below.

- **universal and targeted antenatal and/or postnatal education and support** – for all parents and caregivers (not restricted to birth mothers), delivered by appropriately trained professionals and starting before birth or

in the first year of life, focusing solution-focused counselling, and education covering sleep, managing unsettled behaviour, infant cognitive stimulation, and couple relationship adjustment. [74] Specific programs target vulnerable families.[74]

This can be supported by universal access to online evidence-based reliable information for parents. Examples of Australian sites include [What were we thinking!](#) (Monash University School of Public Health and Preventive Medicine), [Raising Children Network](#), and the [SMS4dads](#) support service. Aotearoa-New Zealand sites include [Parenting resource by age and stage](#) (New Zealand Government Ministry for Children) designed for workers supporting families.

- **targeted home visiting programs**

– for new parents and caregivers (not restricted to birth mothers), targeting families at risk due to adverse experiences, circumstances or difficulties, appropriate for target group and selected or adapted from programs supported by evidence (e.g. Early Head Start, Early Start, Healthy Start, HIPPY, Nurse–Family Partnership, Parents as teachers, right@home, SafeCare).

These can be supported by on-demand services for families experiencing parenting difficulties. In Australia these include [Family and Child Connect](#) (funded by Queensland Government) and the [National Perinatal and Infant Mental Health Connect and Care program](#).

- **targeted interventions to promote parent–child relationships** – targeting parents of infants at risk of insecure attachment and selected or adapted from programs supported by evidence (e.g. Parent-Infant Psychotherapy, Video Feedback to Promote Positive Parenting,

Video-feedback Intervention to Promote Positive Parenting, and Parent Child Interaction Therapy)

- **high-quality early childhood education and care** – for all children, delivered out of home
- **parenting programs** – offered to all parents and targeting families at risk due to adverse experiences, circumstances or difficulties, appropriate for target group and selected or adapted from programs supported by evidence (e.g. Triple P, The Incredible Years, Parent-Child Therapy, Parents under Pressure, Positive Parenting Program, Self-Care, or Tuning in to Kids).

These can be supported by online programs designed to promote wellbeing among new parents. Australian programs include [Baby Steps](#) (Queensland University of Technology and Beyondblue).

- **universal and targeted prevention programs for anxiety and depression** – universal and targeted to preschool children with behavioural inhibition or symptoms, selected from programs supported by evidence (e.g. Cool Little Kids).

Programs developed or adapted for Aboriginal and Torres Strait Islander people include:[75]

- Strong Women, Strong Babies, Strong Culture Program – antenatal care delivered by respected community-based Aboriginal women
- Bulundidi Gudaga – a perinatal and infancy home visiting program adapted from the Maternal Early Childhood Sustained Home-visiting program and the right@home program
- the Australian Nurse-Family Partnership Program (ANFPP) – a home visiting program found to be acceptable by Aboriginal women in a pilot study

- right@home – home visiting program based on the Maternal Early Childhood Sustained Home-Visiting model, implemented with Aboriginal and Torres Strait Islander communities[75]
- Let’s Start – a therapeutic parenting program that helps support the social and emotional needs of children as they begin the transition to school
- Triple P Positive Parenting Program – adapted for Aboriginal and Torres Strait Islander families
- Families as First Teachers – early learning intervention designed by and for Aboriginal and Torres Strait Islander parents
- Home Instruction for Parents of Preschool Youngsters (HIPPY) – adapted for Aboriginal and Torres Strait Islander children
- Mobile Preschool Program – staffed by Aboriginal people.

Programs developed or adapted for Māori include:

- Hoki ki te Rito adaptation of Mellow Parenting.[76]
- Triple P – adapted for Māori and shown to be culturally effective and acceptable. [77]

Various jurisdictions also provide local programs targeting specific groups, such as the Together in Mind Perinatal and Infant Mental Health Day Program in Queensland [78], which provides psychoeducation and support for mothers who have a diagnosed moderate-to-severe mental illness and their infant aged less than 1 year.

Infants and children who show significant social-emotional or behavioural difficulties or have a diagnosed mental disorder need prompt referral to specialised services, such as appropriately trained and experienced clinical psychologists, general psychiatrists, child and adolescent psychiatrists, or infant and perinatal psychiatrists.

Summary of evidence

Note on the evidence: Interventions can be categorised by target age group (e.g. prenatal, neonates, preschool children), setting (e.g. home visiting programs, centre/school-based programs), target risk factors, or types of adversity. There is considerable overlap between these categories within the body of evidence on the effects of childhood mental health prevention and early intervention strategies. For example, antenatal education and support programs, home visiting programs and parenting programs may share aims and content, yet are often separated in systematic reviews selecting interventions based on setting. Reviews focusing on a particular outcome (e.g. preventing maltreatment) or goal (e.g. primary prevention) may include interventions with various modalities or delivered in various settings. Within categories, there is also considerable heterogeneity in the content of interventions and the outcomes measured. This report attempts to summarise benefits reported in systematic reviews according to target group, setting, and components of the intervention, although it is recognised that consistent approaches have not been used, and the evidence in this area is constantly evolving. Psychiatrists or services looking to implement specific programs to support children and families should review available updated evidence where available.

Overall, there is strong support for implementing universal, selective and targeted programs to promote wellbeing and prevent mental illness, provided to families or to children in preschools and schools.[22]

Systematic reviews of interventions to promote children's mental health and wellbeing have found that supporting evidence is strongest for those targeting children who are already showing early signals that they are at risk of developing problems.[5] There is more evidence for the effectiveness of programs that focus on children's behavioural self-regulation than for those focused on attachment or cognitive development.[5]

Interventions targeting age groups or developmental stages

Antenatal/postnatal education and support

Antenatal and postnatal education and support programs are typically designed to educate expectant and new parents in parenting skills including managing infant unsettled behaviour, coping with stressors, promoting positive interactions between partners and stimulating child development. Such programs, when delivered by appropriately trained professionals and starting before birth or in the first year of life, can improve cognitive and social development, infant

mental health (assessed by measures of mood states and behaviours), and reduce child maltreatment.[74] Other benefits of antenatal and postnatal education and support include improvements in infant sleep, preventive care/health-promoting behaviours, parents' knowledge of infant behaviour, parenting quality and couple adjustment.[74]

Application to Australian communities

A review of evidence on promoting social and emotional development and wellbeing of infants, conducted for the Australian National Health and Medical Research Council (NHMRC), concluded that these programs are suitable for universal implementation in Australia, targeting all first-time parents and starting within the first 2 weeks after birth, with the aims of supporting parents/caregivers to maximise their child's social and emotional wellbeing and development, and the prevention of and early intervention for suboptimal infant social and emotional development.[74] The review also concluded that targeted postnatal education and/or support programs could be provided for parents and infants with specific needs identified during pregnancy or after the birth of the baby.[74]

Application to Aotearoa-New Zealand

A 2019 evidence review reported a lack of published literature on kaupapa Māori models of care specifically for maternity, antenatal and postnatal care.[79]

Home visiting programs for parents of infants

Home visiting interventions for new parents aim to promote sensitivity and responsiveness of parents/caregivers, by providing solution-focused counselling, and education covering sleep, managing unsettled behaviour, infant cognitive stimulation, and adjustment in a couple's relationship after the birth of a baby.[74]

Home visiting interventions for parents with particular needs for support (e.g. due to low socioeconomic status, young age or single status), delivered by experienced professionals or trained non-professionals and starting before birth or in the first year of life, are likely to improve parenting quality and interaction, infant cognitive development/intelligence, and sleeping behaviour, and are likely to prevent maltreatment (abuse or neglect).[74]

Home visiting programs that specifically target low-income groups appear to be particularly effective.[5] Among infants and young children exposed to adverse experiences (e.g. maltreatment, maladaptive parenting practices, family dysfunction, violence and socio-economic adversity) some purpose-designed home visiting programs have been associated with improvements in parenting skills and reductions in neglect or child maltreatment, including physical and sexual abuse, and with improvement in children's behaviour. [32]

While there is conflicting evidence for the effectiveness of home visiting programs to prevent or reduce child abuse and neglect,[5, 32] the Early Start program and the Early Head Start program have been shown to reduce child maltreatment,[5, 32] and the Healthy Start Program has been shown to reduce neglect.[32]

Home visiting interventions to prevent later antisocial behaviour and delinquency, starting in the first year of life, are likely to lessen disruptive behaviour during childhood.[74]

The cost-effectiveness of most home visiting programs implemented in Australia and Aotearoa-New Zealand has not been evaluated.[32]

The NHMRC review suggested targeted home visiting programs could be implemented in Australia with the aim of prevention or early interventions for problems that could delay or disrupt infant social and emotional development and wellbeing.[74] Home visiting programs that have been implemented in Australia include specific programs such as right@home, Early Head Start, Healthy Start Program, Parents as Teachers and Home Instruction for Parents of Preschool Youngsters (HIPPY), as well as state and territory-based community child health nurse home visiting programs.[32]

Application to Aotearoa-New Zealand communities

An evidence report prepared for Ministry of Health and Paediatric Society of New Zealand suggested that home visiting programs might benefit lower-risk families referred to child protection services but not meeting criteria for ongoing services. [5] The New Zealand Early Start Home visiting program has been shown to improve parenting and reduce rates of child maltreatment and early problem behaviours.[5, 80, 81]

The 2019 Waitangi Tribunal report[82] also recommended support for families of children aged 0–2 years including home visitation programmes for high-risk families, as a strategy for reducing youth crime.

Nāku Ēnei Tamariki Incorporated Māori Section provides home visiting and group programs for parents.[83]

Interventions for enhancing maternal sensitivity and/or attachment security in infancy and early childhood

Interventions for enhancing maternal sensitivity and/or attachment security, delivered by professionals and trained non-professionals and starting in the first year of life, are likely to be effective in enhancing attachment security in populations with and without risk factors for suboptimal attachment, in families from low to high socioeconomic status, in adolescent and adult parents, and in infants born preterm or full term.[74] Parent-Infant psychotherapy based on a psychodynamic model has also been demonstrated to improve attachment security.[64] Video-feedback Intervention to promote Positive Parenting has shown improvement in maternal sensitivity in RCTs and is supported in The UK's National Institute of Clinical Excellence (NICE) [quality standard on children's attachment](#). [84]

Targeted programs select families considered to be at risk for disorganised infant attachment due to maltreatment or child protection issues, parental mental

health problems, teenage mothers, infant sleep difficulties, or socioeconomic deprivation.[85] Among children with, or at risk of developing, disorganised attachment, parental interventions significantly decrease disorganised attachment, but the effect size differs widely between studies and may depend on the number of sessions.[85]

Targeted interventions delivered to at-risk children older than 6 months may be more effective in preventing or reducing disorganised attachment than those starting prenatally or delivered to parents of infants younger than 6 months.[85] Direct mental health benefits in later childhood, adolescence or adulthood have not been clearly demonstrated.[86]

Application to Aotearoa-New Zealand communities

While several evidence-supported programs designed to enhance parent-child relationships are available in Aotearoa-New Zealand (Appendix 1), there has been a lack of research evaluating programs designed to enhance parent-child relationships in Māori and Pacific people.[86]

The Infant Mental Health Association Aotearoa-New Zealand promotes training in the Facilitating Attuned Interactions (FAN) approach to building parent-child relationships through home visits for children aged 0–3, including trauma-informed care.[87]

Early childhood education curriculum

Social and emotional learning programs delivered in early childhood education and care centres appear to be effective for reducing behavioural and emotional difficulties in children aged 2–6 years, even at relatively low intensity.[88] Programs delivered by professionals with specialised training (e.g. facilitators, specialists, or researchers) may be more effective than those delivered by childcare workers or usual teachers.[88]

School-based programs

Primary school-based mental health promotion programs that focus on resilience and coping skills improve children's ability to manage daily stressors.[89] Improvements have been reported in the use of coping skills, internalizing behaviours, and self-efficacy.[89]

The effectiveness of school-based mental health interventions appears to depend on complete and accurate implementation of the program.[5] Effective programs use teaching skills, focus on positive mental health, start early with the youngest children, balance universal and targeted approaches, continue for a long period of time, and are embedded within a whole-of-school approach, and include teacher education, liaison with parents, parenting education, community involvement, and coordinated work with outside agencies.[5] Mental health benefits are greater among children at higher risk of mental health problems.[5] There has been a lack of research on digital interventions or internet-based approaches to promote mental health in schools.[5]

Programs for preventing child sexual abuse delivered in primary and secondary

schools have been shown to be effective in increasing protective behaviours and knowledge of sexual abuse prevention, but do not reduce children's anxiety levels.[32] It is unclear how long children retain the skills learned in these programs.[5]

School-based anti-bullying programs are effective for reducing bullying.[32] Most aim to increase children's self-awareness, relationship skills, and responsible decision-making as well as teaching children how they can appropriately respond to bullying.[32]

Parenting programs

Parenting programs are generally designed to directly improve parenting skills. Programs differ in the age of children targeted, in design and in theoretical underpinnings. They can be universal or targeted, and are usually delivered in the community settings such as medical centres and day care centres.

Group-based parenting programs have been evaluated in many randomised and quasi-randomised clinical trials.[90] Overall, universal and targeted group-based parenting programs appear to improve emotional and behavioural adjustment and reduce rates of externalising problems in the short term, compared with control conditions, in children aged up to 4 years.[90]

Overall, among families of infants aged 0–2 years at risk of adverse experiences (e.g. due to socioeconomic deprivation, parental psychosocial problems or insecure attachment), parenting programs improve children's behaviour, parent-child relationship and maternal sensitivity.[91] Whether parenting programs also improve child cognitive development or infant mental health outcomes, such as internalising or externalising behaviour in this group of children, has not been clearly demonstrated.[91]

Several parenting programs are effective in mitigating negative impacts of adverse childhood experiences.[32] [92-97]

Parenting programs developed in Australian Indigenous communities include Hey Dad! and the Aboriginal Dads Program.[22]

Application to Māori communities

A 2008 report by the Families Commission *Kōmihana ā whānau* made the following recommendations for strengthening Māori parenting programs: they should not be standalone programs, but provided within health and social services, that providers of *Whānau Ora* services should have access to parenting skills training and resources, and that time and adequate funding must be allocated for program development to allow successful adaptation of source materials to Māori.[98]

Parenting programs subsequently developed for Māori communities include *Hoki ki te Rito/Mellow parenting*, an adaptation of *Mellow Parenting* (www.mellowparenting.org) which has been implemented among Māori women from socioeconomically disadvantaged areas with relationship problems and child behaviour problems and shown to be acceptable. [76]

The 2019 Waitangi Tribunal report[82] recommended evidence-based parent management training programs to build positive parent–child interactions, parental consistency and effective responses to difficult behaviours, as a strategy for reducing youth crime.

Interventions to prevent child maltreatment

While home visiting programs have been shown to reduce child abuse,[99] there is less evidence from studies evaluating other interventions designed to prevent abuse of at-risk children, and results are inconsistent. [99] Few high-quality studies have reported reductions in incidents reported to child protective services.[99]

Most evaluated approaches have been designed for low-income women with risk factors such as young age, depression, family stress, intimate partner violence and lack of social support. Elements associated with effective reduction in child maltreatment include intervention starting in pregnancy and continuing for at least 2 years and weekly visits in the immediate post-partum period.[99]

Primary care-based interventions to prevent maltreatment in children with no known exposure to maltreatment and no signs or symptoms of current or past maltreatment have not been shown to be effective in reducing the rate of reports to child protective services within 1 year of intervention completion.[100]

Intensive crisis intervention, counselling, and life-skills education services for families with children at immediate risk of out-of-home placement due to abuse or neglect may reduce rates of child maltreatment.[32]

Community-wide initiatives to prevent child maltreatment have used a combination of outreach workers along with existing systems and organisations including local government, families, and community organizations, parents, volunteers, and educational staff.[32] Limited evidence

suggests that the Strong Communities initiative improves parenting and reduces rates of child maltreatment.[32]

Interventions to reduce risk in children of parents with mental illness

Few high-quality studies have demonstrated reductions in mental disorders among children of parents with mental illness.[33] Multicomponent interventions that involve professional parenting education, professional mental health counselling, social service referrals, or social support for parents of children aged 0–5 years can reduce the impact of parental mental illness on children’s behaviour and mental health. [101] Interventions delivered in childhood and adolescence have shown small, statistically significant benefits on global psychopathology and on internalising symptoms. Interventions jointly targeting parents and children appear to be more effective.[33] A key principle elucidated in studies is that family-focused service provision increases the likelihood of interventions being effective.

Treatment of perinatal depression, anxiety or psychosis has been found to be cost-effective when the analysis accounts for the prevention of effects on children, such as childhood emotional and conduct problems.[102] Impacts on children represent more than 70% of the cost of maternal perinatal mental illness.[102, 103] Early paternal depression is also a significant predictor of a range of poorer child outcomes. Early intervention to identify and address the mental health needs of fathers is required for the benefit of fathers, children and families. [35]

A systematic review of interventions designed specifically to prevent depression in non-depressed children of adults with depression found that, overall, they produced small statistically significant benefits on depressive and internalising symptoms immediately post intervention, but effects could not be demonstrated at later follow-up intervals.[34] Effectiveness did not differ between psychoeducation and Cognitive Behaviour Therapy (CBT) approaches.[34] The findings suggested that parenting skills might be incorporated into adult psychotherapy. Few studies have assessed effects of such interventions in the long term, including into adulthood.

Some CBT programs are effective for preventing anxiety disorders in children at risk due to a parental anxiety disorder.[104] The Coping and Promoting Strength program has been shown to reduce anxiety diagnoses and symptoms in randomised controlled trials (RCTs) in children aged 6–13 years whose parents had anxiety disorders.[104]

In an Australian study evaluating the Cool Little Kids and Friends parenting group program, which targets 4-year-old children with internalising symptoms, greater reductions in anxiety symptoms were seen among children at highest risk, who had a parent with anxiety.[92, 104]

Systematic assessment of mental health in children at risk due to parental mental illness is difficult to implement because parental mental illness is not always formally diagnosed.[19]

Application to Aotearoa-New Zealand communities

The 2019 Waitangi Tribunal report[82] recommended help with caregiver mental health and substance-use disorders as a strategy for reducing youth crime.

Prevention and early intervention for specific diagnoses and conditions

Depression

Programs to prevent depression in children and adolescents with no known risk factors, or minimal but detectable symptoms of an internalizing disorder, have been evaluated in many RCTs and several systematic reviews.[105, 106] Prevention programs mainly use psychological techniques and are delivered in schools.[105] Overall, these programs are effective in reducing the rate of internalising disorders for up to 9 months post-intervention, whether universal or for early intervention.[105] Depression prevention programs may need to be repeated to achieve long-term effects.[105]

Universal school-based programs for prevention of depression in children up to age 13 years have been shown to be effective post intervention and at long-term follow-up.[107] The FRIENDS program[108-111] and other programs with a large number of sessions are effective in prevention of both anxiety and depressive symptoms.[107] However, one systematic review of universal school-based programs for children and adolescents concluded that those focused solely on the prevention of depression or anxiety were not supported by evidence.[112]

Group-based CBT for subsyndromal depression in children and adolescents reduces the incidence and symptoms of depression, with effects lasting more than 12 months – longer than those achieved within the first year with some other approaches.[106]

Anxiety disorders

RCTs assessing interventions for primary prevention or early treatment of anxiety disorders in children show inconsistent findings.[104]

For preschool children, effective programs for prevention of anxiety disorders and early intervention for anxiety symptoms supported by RCT evidence include the Australian Cool Little Kids program and the UK Timid To Tiger program.[104]

The Cool Little Kids parenting group program is designed for anxiety disorders in children aged 3–6 years who are at risk because of inhibited temperament. RCTs have demonstrated reductions in anxiety disorder diagnoses at 1- and 3-year follow-up.[96, 97] Persisting reductions in internalising disorders and anxiety symptoms into adolescence have been demonstrated in girls, but not boys.[95] Short-term benefits (1-year follow-up) in reducing rates of anxiety disorder diagnoses and internalising symptoms are greater among children at risk due to parental anxiety.[92] The combination of Cool Little Kids with social skills training for children reduces the rate and severity of anxiety disorders in children with high behavioural inhibition levels and parent with high emotional distress.[93] An online adaptation (Cool Little Kids Online), developed to enable widespread dissemination, has also demonstrated reduction in child anxiety symptoms and lower rates of anxiety disorders, compared with waitlist.

In primary school children aged 9–10 years, the universal school-based FRIENDS program, based on CBT and delivered by trained school nurses or other staff, has been shown to reduce anxiety and depressive symptoms.[107] The targeted Coping and Promoting Strength program

reduces anxiety diagnoses and symptoms in RCTs in children aged 6–13 years whose parents have anxiety disorders.[104]

Although several other prevention programs based on CBT or other psychological approaches have been evaluated, most have not shown significant effects on anxiety.[104]

For children with established diagnoses of anxiety disorders, current RANZCP guidelines recommend CBT adapted for the age group as first-line therapy.[113] The guideline also recommend that primary care health professionals should obtain specialist advice before prescribing medications for children.[113] An Australian RCT found that the efficacy of CBT for children and adolescents with anxiety disorders is not significantly enhanced by combination with a short-term course of anti-depressants over and above the combined effects of CBT and placebo. [114]

Behavioural problems

Evidence from studies evaluating programs for preventing and treating oppositional defiant and conduct disorders show that many are effective in reducing diagnoses, symptoms, or both.[115] Features of successful programs include a focus on children at risk, targeting young children, and incorporating training for parents.[115]

Some home visiting programs for new parents have been associated with reductions in criminal behaviour in offspring.[115] These include the Nurse-Family Partnership when commenced prenatally.[115]

Some parenting programs, including The Incredible Years and Parent-Child Interaction Therapy, have been shown to reduce rates of behaviour problems and

diagnoses of behavioural disorders. [22, 32, 115]

The Perry Preschool program for children aged 3–4 years has also been associated with long-term reductions in criminal behaviour.[115]

Several prevention programs targeting school-aged children have been shown to achieve long-term reductions in serious behaviour symptoms such as criminal activity.[115] Good Behavior Game, a US classroom-based universal behaviour management program typically implemented among children aged 6–7 years, has been shown to reduce rates of childhood conduct disorder and adult antisocial personality disorder.[115]

See RANZCP position statement on [Children with conduct disorder](#).

Balancing universal and targeted strategies

The World Health Organization recommends that initiatives to promote mental health must target all members of communities, not only the most disadvantaged, and that the intensity of interventions provided should be proportionate to people's level of need. [14, 116] WHO emphasises that families and caregivers who receive targeted interventions, due to identified risk factors, still need access to universal support.[116]

Services to promote children's mental health and wellbeing – including those aimed at mitigating socioeconomic disadvantage – should be provided for all families, with the level of support matching the level of need.[5, 22, 116]

05.

How can we identify children and families who need special support to maximise mental health and wellbeing?

Identifying children who need more support for mental health and wellbeing starts with identifying mothers and families at risk. Given the association between maternal mental health and infant mental health and wellbeing, screening to detect perinatal depression and anxiety, or other approaches to identify women with these problems, are considered part of a comprehensive strategy for promoting infant wellbeing.

Screening or otherwise working with parents and parents-to-be to identify substance use would facilitate early referral to alcohol and other drug services, to minimise adverse effects on unborn children, infants and children.

Pregnancy and early childhood is time when parents are frequently in contact with health services, so this provides an ideal opportunity for screening and early intervention. To be effective, this must not be limited to screening or case-finding for anxiety and depression, but must involve processes for identifying psychosocial risk factors that predict maternal mental health challenges and parenting difficulties. Screening/case-finding and referral to appropriate support must continue beyond birth.

A comprehensive screening or identification program will involve training and education of maternity care providers, as well as supervision and ongoing support. Perinatal psychiatrists should be involved in planning and providing this education and training.

Screening or case-finding must be embedded in a framework of well-functioning referral pathways and responsive services that are flexible and adaptive to the needs of clients, including hard-to-reach populations with high levels of multiple risk factors for psychosocial adversity and mental health problems (e.g. teenaged mothers, women with chronic mental illness, and women with history of trauma.)

Screening and support systems for Aboriginal and Torres Strait Islander women and their families must be designed and implemented by these communities, embedded in culture and ensuring cultural safety. A recent systematic review of child developmental tools adapted for use in children from Aboriginal and Torres Strait Islander background found the need for further research on accuracy, acceptability, and feasibility.[117]

Systems to identify needs and provide support for Māori must work with families and whānau, valuing whānau input and acknowledging Kaupapa Māori approaches.

Systems for Pasifika must consider cultural and community perspectives and relationships.

Systems must also consider the needs of culturally and linguistically diverse communities in Australia and Aotearoa-New Zealand.

Screening for parents is less researched and not commonly practised in Aotearoa-New Zealand, but is recommended in Australia. Holistic screening for maternal mental illness, intimate partner violence and family violence, should be coupled with provision of appropriate services and support.

Summary of current practices

A range of tools have been developed for screening and assessments relevant to early childhood mental health and wellbeing (Table 2).

Table 2. Examples of tools used in screening and assessment of mental health risk in infants and children

Perinatal screening	Edinburgh Postnatal Depression Scale[118, 119]
	Kimberley Mum's Mood Scale
	Antenatal Risk Questionnaire[120]
Parent-child relationship	Maternal postnatal Attachment Scale[121]
Adverse experiences	The Adverse Childhood Experiences Questionnaire (ACE-Q)
Development and social and emotional wellbeing of infants and children	Neonatal Behavioural Assessment Scale (ages 0–2 months)
	Nursing Child Assessment Satellite Training (NCAST)
	Parent Child Interaction Assessment Scales: Feeding (0–12 months); Teaching (0–36 months)
	Modified Alarm Distress Baby Scale (assesses social withdrawal)[122]
	Ages and Stages Questionnaires: Social-Emotional[123] (ages 6 months–5 years)
	Learn The Signs Act Early (Centre for Disease Control CDC) (birth to 5 years) (https://www.cdc.gov/ncbddd/actearly/index.html)
	Survey of Wellbeing of Young Children (SWYC) 2 to 60 months (https://pediatrics.tuftsmedicalcenter.org/the-survey-of-wellbeing-of-young-children/overview)
	Parents' Evaluation of Developmental Status (ages 0–8 years)
	Paediatric Symptom Checklist (ages 4–18 years)
	Strengths and difficulties questionnaire (SDQ) (https://sdqinfo.org ; ages 3–16 years)
	Brigance Screens (ages 0–7 years)
	Modified Checklist for Autism in Toddlers (ages 16–30 months).
	Brief Infant-Toddler Social and Emotional Assessment[124] – screens children aged 12–36 months for social-emotional and behavioural problems and competencies
The Health of the Nation Outcome Scales for Infants (HoNOSI) [125]	
Diagnostic measures of child mental health	Preschool-Age Psychiatric Assessment[126]
	Child and Adolescent Psychiatric Assessment

Maternal antenatal and perinatal screening

Given the association between maternal mental health and infant mental health and wellbeing, screening to detect perinatal depression and anxiety, and provide effective treatment and support, are considered part of a comprehensive strategy for promoting infant wellbeing.

See RANZCP position statement [Perinatal mental health services](#).^[8]

Australia: The Australian Productivity Commission's 2020 report on mental health has called for universal screening for mental ill-health of new parents as a priority reform.^[9] It notes that the frequent interactions of families with healthcare providers during the perinatal period provide an opportunity to detect mental health problems and offer early intervention.^[9] However, detection of risk factors for mental illness during perinatal screening does not ensure that women receive assessment or treatment. Barriers to access include stigma and lack of available services.^[9]

Screening for Aboriginal and Torres Strait Islander women should consider language and cultural appropriateness of the tool.^[57]

Current Australian guidelines for perinatal mental health care^[57] recommend screening women for a possible depressive disorder in the perinatal period using the Edinburgh Postnatal Depression Scale (EPDS), with further assessment for those identified at screening. There are items in the EPDS that screen for anxiety but it further recommends screening for anxiety using items from various tools including Antenatal Risk Questionnaire, and assessment of psychosocial risk using the Antenatal Risk Questionnaire, which also screens for past mental health problems,

in conjunction with depression screening.^[57] The Kimberley Mum's Mood Scale is an adaptation of the Edinburgh Postnatal Depression Scale validated for use with Aboriginal women in the Kimberley region of Western Australia.^[127]

Some jurisdictions implement antenatal and postnatal screening for psychosocial risks to infants, including those due to family violence.^[4]

Aotearoa-New Zealand: Universal screening for substance use among new parents has been recommended (e.g. at the first antenatal contact and subsequent visits).^[28]

An evidence review prepared for the Well Child Tamariki Ora Programme found that it was not possible to identify the most appropriate tools for screening for perinatal depression and anxiety in Aotearoa-New Zealand, and that there was poor uptake of interventions for people with screen-detected mental health problems in the perinatal period.^[56] The cultural validity of screening for Māori and Pacific women has not been established.^[56]

Assessment of parent-child interaction

Parent-child relationship problems may be identified by observing the interaction between the parent and the infant, as well as considering the presence of risk factors for relationship problems.^[86]

However, caution is needed when health workers conduct and assess attachment. The use of screening tools specifically to identify parent-child relationship difficulties is not well supported by high-quality evidence.^[86] The assumption by healthcare professionals that disorganised attachment pattern is a sign of child maltreatment is a potential harm of such screening.^[86]

Infant screening and monitoring of development

Australia: The following tools have been validated and are currently available and appropriate for use in Australia for general developmental monitoring:^[128]

- the Neonatal Behavioural Assessment Scale (ages 0–2 months)
- Nursing Child Assessment Satellite Training (NCAST) Parent Child Interaction Assessment Scales: Feeding (0–12 months); Teaching (0–36 months).

The Australian Productivity Commission has suggested that the existing optional physical development checks of infants aged 0–3 years, provided in community health services, could be expanded to include social and emotional wellbeing aspects of development and provide referral to mental health services where needed.^[9]

Aotearoa-New Zealand: The Strength and Difficulties Questionnaire has been recommended for universal screening of infants and young children in Aotearoa-New Zealand, with children identified as being at risk referred for comprehensive assessment with attention to observations of the parent-child relationship.^[5]

Identifying parental mental illness beyond the perinatal period

Given that parental mental illness is risk factor for mental illness in children, there is potential for adult mental health services to identify children for prevention and early intervention. However, clinical practice guidelines for the management of adult mental illness rarely mention the risk of mental illness in offspring or include explicit guidance on the management of this risk.

Australia: Australian guidelines for the management of borderline personality disorder explicitly recommend that people with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships.[129]

Australia and Aotearoa-New Zealand: RANZCP guidelines for the management of schizophrenia and related disorders provide guidance on antenatal and maternity care, and mention parenting skills and custody of children as issues for women with psychoses.[130] Guidelines generally do not recommend monitoring of the mental health of a patient's children or consideration of referral to children's mental health services.

Adverse childhood experiences

The adverse childhood experiences questionnaire (ACE-Q) is used in the USA to record the number of childhood adversities and identify children who require further assessment and intervention.[70]

Formal screening tools for assessing adverse childhood experiences are not currently used in Aotearoa-New Zealand[70] or routinely in Australia.

Emerging mental health problems in infants and children

Australia: The Royal Australian College of General Practitioners recommends that general practitioners regularly use the Parents' Evaluation of Developmental Status.[131].

The Productivity Commission report 2020 has called to make social and emotional development of children a national priority. While state governments have implemented developmental surveillance programs, the

uptake is low with only 30% at 12 months of age and even less children accessing it after 12 months in some jurisdictions.[132] There is also significant inequity in access to prevention and health promotion services with an 'inverse care law' of those from most disadvantaged backgrounds with highest rates of developmental delay and socio-emotional concern least accessing the developmental checks.[133] Delays in detection of developmental problems prevent access to early intervention with consequent adverse long-term outcomes. Hence there is an urgent need to develop a national contemporary unified model of early childhood developmental and socio-emotional screening that engages parents, addresses existing inequalities and improves universal developmental surveillance in the preschool years.[10] In this regard novel digital platforms have been developed to identify child development, parental mental health and family psychosocial needs using opportunistic contacts such as vaccination and routine health care visits [6] that has been shown to be feasible and acceptable.[7]

Aotearoa-New Zealand: The Strengths and difficulties questionnaire is currently used for universal screening of social emotional and behavioural difficulties among 4-year-old children in Aotearoa-New Zealand.[70]

Screening children and adolescents for major depressive disorder in primary care has not been shown to directly reduce rates of depression or improve other health-related outcomes.[134] Some screening tools (e.g. Beck Depression Inventory and Patient Health Questionnaire for Adolescents) show acceptable accuracy in identify depression in adolescents in primary care. However, there is a lack of evidence for the accuracy of depression screening tools and the effects of screening on clinical outcomes in children younger than 12 years.[134] There is little evidence directly linking strategies for screening infants and children for mental health problems, and outcomes in childhood, adolescence or adulthood.

Diagnostic assessments

Mental disorders diagnosed in infancy and early childhood include neurodevelopmental disorders (e.g. autism spectrum disorder, ADHD), anxiety disorders (e.g. separation anxiety), mood disorders (e.g. depressive disorder of early childhood, disorder of dysregulated anger of early childhood), obsessive-compulsive disorders, sleeping, eating and crying disorders, trauma- and stress-related disorders, and relationship disorders.[135] Conduct disorders, such as oppositional defiant disorder and disruptive behaviour disorder, are generally diagnosed in school-aged children. Major depressive disorder uncommon in children and may present as irritability rather than depressed mood.[136] Although term 'juvenile' or 'paediatric' bipolar disorder is increasingly used by some clinicians,[136, 137] bipolar disorder cannot be reliably diagnosed in young children.[136]

It can be difficult for clinicians to discern whether or not a child has a significant mental health problem, because children's ability to regulate their social interactions, emotions and behaviours depends on individual developmental stage and varies according to caregiver characteristics and situations.[5] However, it is important to identify significant behavioural and mental health problems early, so that effective interventions can be offered before problems become severe.[5]

Where required, diagnostic assessments for children with symptoms and signs suggesting a mental illness are performed by psychiatrists and other health professionals according to relevant guidelines. Current screening and case-finding strategies aim to identify known risk factors for mental health problems, or to detect early signs of social, emotional and behavioural difficulties in infants well before diagnostic assessments can be made.

06.

How can we better integrate support for infant and child mental health into Australia and Aotearoa-New Zealand systems?

Overarching principles and approach

Prevention and early intervention to support optimal children's mental health and wellbeing requires a whole-of-system approach. Building effective systems for support, screening and case identification across our tiered systems is essential.

Systems for providing services and interventions must be flexible to accommodate the needs of the individual child or family.

Australia: All involved in providing services to parents and children should work alongside families. Interventions for Aboriginal and Torres Strait Islander parents should be based on cultural values and delivered in a culturally appropriate manner.

Aotearoa-New Zealand: All involved in providing services to parents and children should work alongside families and whānau, valuing whānau input and acknowledging Kaupapa Māori approaches. Health care planning involves obligations under Te Tiriti o Waitangi. A review of local initiatives to support

families, including in high-deprivation areas, found that effective initiatives were based on three principles: they work holistically, recognising that if families are well, children are well, and approach families as part of communities; they counter the culture of disempowerment, and they identify and build on the positive: Instead of asking about the issues and problems for '*vulnerable children*' or '*high-needs families*', we ask '*what's working?*'. [138]

Relationships and links

Workers in the health sector and related agencies who work with pregnant women and parents can help foster the crucial relationship between mother and baby, relationships within families and whānau, and relationships of parents and families to their community.

Existing relationships between families and services (e.g. general practices and other primary care services, adult mental health services, other services) should be harnessed in a way that supports young children and families and protects children.

Parents' engagement with early intervention strategies depends on continuity of care across all services, e.g. continuity between midwifery care and child health care services.

Effective communication must be established between all health organisations and agencies that work with pregnant women, mothers and families.

Embedding child-nurturing and protection actions at all levels of systems

Selected prevention and intervention strategies should be incorporated into existing programs and services, including antenatal and maternal health services, community health service, primary care.

To achieve this integration, it will be necessary to strengthen existing services, which are currently strained.

Training and education needs

All workers in the health sector and related agencies need education to develop an understanding of infant mental health prevention and early intervention strategies. This includes midwives, child health, general practice, early childhood education services, and family support services.

Maternity care services require training in trauma-informed care to enable them to recognise and provide appropriate care for women with a history of trauma. This would both avoid re-traumatisation and encourage women to engage in services that can support their child's mental health and wellbeing.

Health workers who conduct prenatal and postnatal screening to identify families' needs for extra support for infant mental health and wellbeing require appropriate training and supervision.

Children in care

Children in care require early access to comprehensive, multidisciplinary assessment and intervention to prevent further trauma (including by the service system). This approach supports children in care to reach their full psychosocial, emotional, physical and educational potential.

Aboriginal and Torres Strait Islander children, tamariki Māori, and children from culturally and linguistically diverse communities have specific, additional relational contexts and needs, such as the need for access to a wider range of services, for cultural safety applied across clinical settings, and for services to

understand and consider interrelationships at community, regional, and wider societal levels. These needs should be well understood, recognised and supported by relevant policies and care practices.

Services and care pathways should be child-focused and work alongside the family and whanāu (see RANZCP position statement [The mental health needs of children in care or at risk of entering care](#) [139]).

Research needs

Māori and Pasifika are young populations and will soon represent the majority of children served by the healthcare system. There is a need for better understanding of their needs and development and evaluation of strategies developed by these communities for early intervention among children.

All research relevant to the mental health and wellbeing of infants and children should incorporate outcome measures that will permit meaningful comparison between studies. Locally relevant outcome measures should be developed and tested, where needed. The Health of the Nation Outcome Scales for Infants (HoNOSI) has been developed to address a gap in routine outcome measures of social, emotional and behavioural domains for pre-schoolers and infants in Australian mental health services.[125] The positive evidence for this supports a controlled release of the HoNOSI accompanied by further research and development.

Linking services in a comprehensive support network

Links between services should be clearly defined and function well. Within our current systems there is a need for reinforcement at weak points, including the transition from one age group-based service to the next, and links between services. A family-focused approach can be compromised by 'silo' models, e.g. when children, adolescents and youth mental health services operate separately and are also disconnected from adult mental health services.

Mental health services need to be designed to prevent at-risk children becoming lost to care at the points of transition from perinatal to child and adolescent services, or between infant-focused and children's programs. Evidence from Australia, Europe and Canada suggests that transition from child and adolescent mental health services to adult mental health services is rarely optimal, and frequently results in treatment delays, failure of referral, or appropriate discharge.[140] There is a lack of data to assess mental health outcomes in young people after being transferred.[140]

Children's mental health services must focus on the needs of whole families, because a child's mental health is influenced by community and family factors including parents' mental health, socioeconomic deprivation, community safety, and problems at school.[5] Similarly, adult mental health services must consider the mental health needs of clients' children.

Links between services should be explicitly identified, workable and well understood by all health professionals and other

providers. This includes referral pathways specialist psychiatric services from community mental health services and other health services.

In Aotearoa-New Zealand, the delivery of interventions for child mental health problems often requires coordination between multiple agencies and services, such as well child services, general practice, early childhood education, schools and school-based health services, special education, child and adult mental health services, paediatric specialists, Oranga Tamariki, youth forensic mental health services, disability support services, and non-governmental organisations.[5]

In Australia, the involvement of agencies and services differs between states and territories.

Intergenerational psychiatry focuses on preventing the transmission of mental disorders from parents to offspring due to inherited genetic and environmental risk factors, and countering the effects of parental trauma or prenatal exposure to stress or anxiety/depression.[141] Approaches include child-centred psychiatry, family-focused psychiatry, which can incorporate prevention throughout the family structure. Aims include the prevention of neglect and abuse, and mitigating the psychosocial effects of adverse childhood experiences including trauma, socioeconomic disadvantage, and parental drug and alcohol use.

The UK Thrive framework[142] promotes the model of a joined-up system in which all relevant agencies and levels are linked, and everyone who works with parents or children is aware of child mental health issues. The aim is that anyone who first identifies a risk or early sign of a problem – whether a teacher, GPs or

support staff – will know the most helpful response and can direct the child or family for appropriate support or care.[142] In Australia, an integrated continuum of connect and care model (I-CCC) has been proposed to integrate all relevant mental health services along a tiered care pathway that identifies and meet the specific needs of each child/young person and their family.[11] The aim is to integrate the current fragmented service delivery through a comprehensive assessment such as using the Initial Assessment and Referral (IAR) framework [143] followed by link up to relevant matching services within primary, secondary and specialised services.

The Australian Productivity Commission similarly recommends that schools should be effective gateways for students and their families to access help for mental health problems.[9]

For Australian Aboriginal and Torres Strait Islander people, gaps in services have prevented smooth transitions from family and community services to primary and specialist mental health care services, and then back into the community.[144]

In Australia it is difficult for health professionals in different parts of the mental health system to collaborate, share information and coordinate care.[9] The Productivity Commission has recommended that governments remove barriers to cooperation and reform funding arrangements to encourage and facilitate collaboration.[9]

Providing culturally appropriate services

Effective service delivery for Aboriginal and Torres Strait Islander and Māori families and communities requires a commitment to working with – not for – first peoples.

[5, 75] It is essential that Indigenous communities are involved in the design and delivery of services.[75] Delivery of services must involve respect for language and culture, be based on holistic and integrated approaches, with a focus on recognising and building strengths, and address trauma.[75]

Infant and child services for Aboriginal and Torres Strait Islander or Māori families should be provided by skilled practitioners with high levels of cultural competence.[75]

In Australia there is currently a deficit in the cultural capability of clinicians treating Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.[9]

Aotearoa-New Zealand

The 2013 Inquiry into the determinants of wellbeing for tamariki Māori recommended prioritising the needs and wellbeing of tamariki aged up to five years in all policy and legislative processes with a direct or indirect impact on children. [68]

The Child and Youth Mortality Review Committee and Suicide Mortality Review Committee's 2020 report made four major system-level recommendations for all of government:[63]

1. Embed and enact Te Tiriti into all policy and practice to support mana motuhake, accelerating this process for rangatahi within the education and health sectors.
2. Urgently address the impact of socioeconomic determinants of health on whānau, including

poverty, alcohol, racism, housing and unemployment.

3. Invest in what works for Māori, iwi, hapū and whānau – invest in, fund and build communities to lead initiatives that support communities in suicide prevention and postvention.

4. Work collectively, nationally and locally to leverage government investment in what works for Māori.

Whānau Ora

Whānau Ora is an evidence-based, by Māori for Māori, approach to Māori health and wellbeing. Within this approach:[145]

- Māori whānau are recognised and supported as the principal source of connection, strength, support, security, and identity for health and wellness.
- Māori are at the centre of decision making and provides access to resources that support self-determination and develop whānau strengths.
- Whānau wellbeing is aligned with Māori cultural and spiritual values, alongside social and economic priorities.

Pacific families

A 2015 evaluation of a project to support Pacific families reported that developing an effective partnership with Pacific families involved recognising power imbalances and working in partnership with clients and with other providers, to provide a service that best met the needs of the family. Families named cultural differences as one of the barriers to engaging with the program.[146]

Delivery models

Incorporating mental health services into existing services has been proposed as an effective way to deliver preventive or treatment interventions.

Embedding infant mental health and wellbeing services into existing universal postnatal support or home visiting programs might improve uptake and help overcome current limitations of strategies for improving postpartum and infant care, given that the use of risk factors to target parents does not ensure all at-risk children are identified, and may result in stigma. [147] However, few high-quality studies have evaluated interventions designed to enhance health service contacts in existing services, and improvements in social-emotional wellbeing at age 3 years have not been demonstrated.[147]

Collaborative care models that integrate multidisciplinary teams, including mental health specialists, into primary care settings have shown benefits for the delivery of mental health care for children and adolescents with depression, anxiety or behaviour problems.[5] Other effective delivery strategies for children and adolescents include co-locating behavioural health services within primary care practices, and integrating behavioural care through web-based or phone services. [5] Co-location of mental health services within other services that families routinely visit is thought to increase use of services by removing barriers to access and reducing the stigma.[148] This is aligned with the recent Australian government initiative to establish 'head to health' hubs to co-locate services.

Delivery models in Australian communities

Best Start is a model of coordinated service delivery for Aboriginal and Torres Strait Islander families with young children. It involves a range of family-friendly services in nutrition and health education, early language and numeracy, playgroups and integration into pre-primary school programs. An evaluation of the program at six sites reported benefits including improved social and learning outcomes.[75]

Delivery models in Aotearoa-New Zealand communities

Whānau Ora is an inclusive inter-agency approach to providing health and social services that focuses on building the capacity of Māori families.[75, 149] The funding and service delivery model aims to work with Whānau (extended families) as a whole, rather than focusing separately on individual family members. Each Whānau has a 'navigator' who works with their Whānau to identify needs, develop a plan, and broker access to a range of health and social services. [75] Whānau Ora has evolved since its launch in 2010, and has been broadened to all New Zealanders.[150]

Naku enei tamariki Incorporated is organisation delivering culturally responsive programs for Māori, Pasifika and Pākehā families/whānau.

Although school-based interventions have often been promoted to improve children's access to mental health care, few comparative studies have demonstrated increased access or improvement in mental health outcomes.[151] Some researchers propose that population-wide access to mental health care might be optimised by a two-stage interventions that first identify children in need and then engage them in the healthcare system.[151] Fear of stigma can be a barrier to children's use of targeted school-based mental health interventions including counselling services.[152]

Limited evidence suggests that policy settings that support co-location of children's mental health services with existing services (mainly school-based services and integrated health care) are associated with increased use and acceptability of services.[148]

Policy context

Efforts to maximise children's mental health and reduce the long-term burden of mental illness require whole-of-community approaches. Children's mental health promotion requires action across multiple sectors and levels, because risk and protective factors act at the individual, family, community, structural, and population levels.[116]

Australia

National framework

In Australia, the new National Children's Mental Health and Wellbeing Strategy is based on eight principles: (1) giving priority to the interests and needs of children, (2) all services to adopt a perspective that builds on child and family strengths, (3) universal and targeted prevention of mental

illness by promoting mental wellbeing, (4) ensuring that all children and families have access to health, education and social services, (5) ensuring that programs and services are developmentally appropriate, culturally responsive and treat children in the context of families and communities, (6) using continuous quality evaluation and research evidence to ensure practice remains evidence-based, (7) providing early intervention for those in need, while addressing the impacts of trauma and social determinants, and (8) based on individual needs, with a reduced focus on requiring a diagnosis to access services.

The framework proposes a shift towards a continuum-based model of mental health and wellbeing (well, coping, struggling, unwell), avoiding terminology that may be stigmatising or too narrow to capture the full range of a child's emotional experiences. The continuum approach highlights that there are opportunities to promote improved wellbeing and possibly intervene before a child becomes unwell. It also focuses on a child's functioning rather than diagnosis.

Current policy supporting perinatal mental health care

The Council of Australian Governments (COAG) Health Council strategic plan[153] includes improvement of perinatal mental health through effective sharing of information between all services involved in a woman's care and with the woman herself, inclusion of perinatal mental health in health professional training, and professional development in perinatal mental health for the existing maternity care workforce. COAG supports implementation of the national clinical practice guideline for mental health care in the perinatal period.[57]

Current policy supporting children's mental health in preschools and schools

The Australian Productivity Commission found that much of the policy infrastructure required to achieve substantial improvement in early intervention, prevention and promotion of mental health and wellbeing in early childhood and schooling is already in place.[9] However, it identifies barriers including competing priorities, lack of clarity due to multiple policy documents and frameworks, and inadequate tracking of outcomes.[9]

Aotearoa-New Zealand

Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing is shifting to a stronger focus on addressing the wider determinants of mental wellbeing and promoting mental wellbeing across communities, whānau and individuals, from a primary focus on providing services that respond to individuals' mental health and addiction needs.[154] This new framework focuses on (1) building the social, cultural, environmental and economic foundations for mental wellbeing, (2) equipping communities, whānau and individuals to look after their mental wellbeing, (3) fostering community-led solutions, (4) expanding primary mental wellbeing support in communities, and (5) strengthening specialist services. Upholding Te Tiriti o Waitangi by ensuring equity of mental wellbeing outcomes for Māori is an important foundation principle of the policy framework.[154]

Current policy supporting perinatal mental health care

Aotearoa-New Zealand's Child and Youth Wellbeing Strategy includes actions to improve maternity and early years support, provide intensive parenting support, and

expand pregnancy and parenting services through the 5-year Maternity Whole of New System Action Plan and review of the Well Child Tamariki Ora programme.[155]

Current policy supporting early support for whānau

The Ngā Tini Whetū program for whānau-centred early intervention was introduced in 2021. The program is a collaboration between Oranga Tamariki, Te Puni Kōkiri, Accident Compensation Corporation (ACC) and the Whānau Ora Commissioning Agency.[156]

Current policy supporting children's mental health in preschools and schools

Aotearoa-New Zealand's Child and Youth Wellbeing Strategy includes actions to promote positive and respectful peer relationships through initiatives to prevent and respond to bullying in schools, and to expand healthy relationship programmes in secondary schools.[155]

Aotearoa-New Zealand's Child and Youth Wellbeing Strategy includes expanded access to primary mental health and greater choice of services, including initiatives to promote wellbeing in primary and intermediate schools.[155]

Current policy to reduce child poverty

The Child Poverty Reduction Act 2018 is intended to improve housing affordability and quality, reduce food insecurity, promote regular school attendance by children, and reduce rates of potentially avoidable hospitalisation.[157]

Current policy to reduce family violence and sexual violence

The National Strategy to Eliminate Family Violence and Sexual Violence acknowledges

that housing affordability, food insecurity and related issues cause financial stress and instability for many families. While whānau often work to protect children from the severity of these issues, they can impact parents' relationships and mental health, which in turn impacts children.[158]



07.

How can the psychiatry workforce be deployed more effectively in Australia and Aotearoa-New Zealand to support infant and child mental health?

A mental health system that effectively promotes infant and child mental health and wellbeing requires a highly skilled workforce with well understood roles and effective intercommunication.

Adult psychiatrists, with the support of perinatal psychiatrists, can support women before they become pregnant to prioritise any future child's mental health and wellbeing when planning or avoiding pregnancy. Adult psychiatrists can also support potential fathers, with the goal of safeguarding and fostering children's mental health and wellbeing. Links between alcohol and other drug services

are also important with referral pathways for early support.

Perinatal psychiatrists should be adequately trained and funded to support maternal mental health, parenting and the mother-infant relationship, and infant health and wellbeing, considering the woman's partner, family, and key supports in the planning and delivery of care.

Specialist perinatal mental health services are well recognised in helping treat mothers as well as supporting infant wellbeing and the relationship between mother and baby. These services are also increasingly focussing on partner's and father's mental health. Evidence demonstrates improved outcomes for those families who are able to access these specialist services. These services also frequently provide expertise in women's mental health in the reproductive years.

The perinatal psychiatrist workforce should be expanded and integrated with maternity care via consultation liaison services. There should be a continuum of perinatal mental health services from consultation liaison services, community, and inpatient services, integrated with infant mental health services.

Perinatal psychiatry services must establish strong links and collaboration with general practice, child health services, family support services and adult mental health services, and alcohol and other drug services. This includes links with child protection services and services for children in care and families who experience domestic and family violence to provide expert advice regarding parental mental health and impact on parenting and infant mental health.

Perinatal psychiatrists should be involved in the training, education and supervision of maternity and child health services, to increase the skill base for the identification and appropriate management of women with peripartum mental health issues.

Perinatal psychiatrists should be involved in screening for maternal mental health and parenting risk factors, to ensure effective early identification of risk and referral of women to appropriate service in the peripartum period.

Maternity services should be designed for continuity of care throughout pregnancy and the 'fourth trimester'. There should be clear communication between all providers, and with explicit protocols for handover to primary care and child health for of vulnerable mothers and babies, so they can be referred to early intervention programs.

Multidisciplinary care should be provided to mothers with multiple comorbidities, including mental health problems, family violence, substance and alcohol misuse, and other psychosocial adversities including personality dysfunction.

Women with severe mental illness (e.g. schizophrenia, bipolar disorder, severe depression or borderline personality disorder) should receive coordinated team-based perinatal (ante and postnatal) care that involves integrated parent and infant mental health care and intensive maternal child health care.[57] Continuity of midwifery and obstetric care is important. If a mother with severe postnatal mental illness need to be hospitalised, she should be offered a specialist mother-baby unit to avoid separation from her infant.[57] Multidisciplinary teams and specialist perinatal mental health services must be integrated into antenatal care as part of maternity care. Fathers' mental health

problems also need to be addressed by appropriate services given the adverse impact their difficulties have on infant and child development.[35]

See also: RANZCP position statement on [perinatal mental health services](#).

A strong and coherent mental health system requires attention to infant and child mental wellbeing practised within roles and at all levels.

Roles of specialist psychiatry services

All services that provide health care to target groups (including pregnant women, infants, children and adolescents) require the involvement of psychiatrists, to enable effective mental health care to be integrated into children's care across the spectrum. Well-delineated and effective communication and referral pathways need to be established to allow general psychiatrists, working within all types of services and levels of the health system, to liaise effectively with other health professionals including GPs and paediatricians.

Child and adolescent psychiatrists currently work in in primary care settings such as public mental health services, various secondary and tertiary settings such as specialist community child and adolescent mental health services/ community child youth mental health services, private outpatient practice, non-government organisations, paediatric medical services, inpatient mental health services and hospitals, juvenile justice. Involvement of a child and adolescent psychiatrist is essential in the management of psychosis, severe depression, self-harm, suicide or harm to others, and in responses

to child abuse, neglect and trauma.[159] Their involvement is also recommended for children with or at risk of developing a mental illness where the disorder is complex and severe or requires hospitalisation, a physical cause is suspected, or when clinical leadership is needed for multidisciplinary and multiagency care.[159] A stepped care model that includes integrated primary, specialist and e-mental health care requires child and adolescent psychiatrists to develop partnerships and support primary level interventions, as well as focusing on specialist assessment and treatment for children with moderate to severe mental health problems.

Perinatal and infant psychiatry is an emerging field. Perinatal, infant and early childhood mental health services are central to the effective promotion of child mental health and wellbeing (see RANZCP position statement on [perinatal mental health services](#)). [8] The role of perinatal and infant psychiatry should be expanded to work with parents earlier in the infant's life and continue to support infants and their families through a smooth transition to children's mental health services. Public mental health systems should incorporate dedicated, well-funded perinatal and infant psychiatry services as a core component, yet in some jurisdictions these are currently offered as add-on services to be deployed only as required, or not funded at all.

Tertiary child and adolescent mental health services provide specialised care for children with the most serious and complex needs. They should also be enabled to provide advice and oversight to other levels, to support health professionals at all levels to provide high-quality evidence-based care mental health care.

Mental health services need to be responsive to changing developmental

needs in the context of family and attachment relationships.[160]

Currently there are too few child and adolescent psychiatrists in Australia and Aotearoa-New Zealand to fully fill all these roles and meet predicted future needs. [9, 13] There is also an overall shortage of psychiatrists, especially in rural and regional Australia, which results in high costs and long waiting times.[9] The Australian Productivity Commission has identified a lack of mental health inpatient beds for children and adolescents in some Australian states and territories, emphasising that these must be provided in wards that are separate from adult mental health wards. [9]

Australia has an aging psychiatric workforce and currently relies on overseas-trained psychiatrists.[9] The Australian Productivity Commission's 2020 report calls for a national plan to increase the number of psychiatrists in clinical practice, particularly outside major cities and in child and adolescent subspecialties.[9]

Roles of community mental health services

Community mental health services have a central role in prevention and early intervention. Staff at these services can develop a strong understanding of the needs of the communities they work with, provide tailored support to parents and children, and help reduce stigma. Community mental health services are ideally placed to help patients and health professionals navigate health systems within their jurisdiction.

The Australian Productivity Commission has identified a need to expand child and

adolescent community mental health services to meet current needs.[9]

Role of primary care

GPs in Australia and Aotearoa-New Zealand are essential providers of mental healthcare services.[9]

A recent Aotearoa-New Zealand report called for a greater role for primary care in identifying mental health problems in children and supporting mental wellbeing, given that GPs see children and their families for a range of other conditions, understand their circumstances, and are able to build relationships of trust.[5]

Current barriers to greater involvement of GPs in children's mental health care include parents' reluctance to disclose children's emotional and behavioural problems, short appointment times, lack of reimbursement for extended consultations, GPs' lack of training in managing children's mental health, and lack of referral pathways and links with specialist services.[5] Planning and resourcing, including are needed to overcome these problems and ensure strong links with specialised psychiatry services.

GP access to support and advice from psychiatrists on the management of patients with mental health issues is particularly valued. Effective two-way communication between the child and adolescent psychiatrist and GP can help facilitate better care for patients and benefit patients by continuing in primary care, giving them access to secondary care when necessary.

Enablers include training and education for GPs on child mental health, provided through the Royal Australian College

of General Practitioners (RACGP) and presented by Emerging Minds, which delivers the National Workforce Centre for Child Mental Health in partnership with RACGP and other organisations.

Roles of all health professionals

A 2019 report prepared for the NSW Ministry of Health concluded that current evidence supports investment in education and support of all health professionals working with parents and potential parents, to enable them to identify and manage mental health risks early, during a child's first 2000 days. It argued that investment would benefit individuals and society by improving children's overall health, development and lifetime success. [4]

Role of early childhood services

The Australian Productivity Commission has recommended that the ability of early childhood education and care centres and schools to support children's social and emotional development be strengthened through initial training and professional development.[9] Preschool and day care staff need training in recognising emotional, social and behavioural problems in young children. Where possible problems are identified, they need clearly defined and feasible referral options.

Preventive and early intervention programs, such as Cool Little Kids for anxiety, can be incorporated into preschool curricula or offered through preschool settings. The Australian Productivity Commission has recommended a system of accreditation for wellbeing programs offered by external

providers.[9] This is important in early childhood to ensure that school readiness is optimised.

Roles of other agencies

A range of other professionals must be involved to effectively to promote infant and child wellbeing, identify risk or manage prevention/early intervention in young children. These include health workers and other staff in adult-focused agencies such as family support, health, and alcohol and other drug services. These services can play an important role in promoting children's mental health wellbeing and health by supporting parents and addressing children's difficulties.[161]

Targeting public attitudes and understanding

Community-wide support for infant and child mental health and wellbeing requires increased public awareness of children's mental health.

People assume that children's worlds are simple and worry-free, and may not believe that children can experience difficult emotions or stress before the age of 5 or 6 years.[162]

Parents may face significant stigma when referred to mental health services with their infants and children. Public education is needed to overcome stigma associated with infant and child mental health care, just as it has been necessary to work hard over recent years to reduce stigma for adults with mental illness. This could be achieved by increasing people's awareness

of mental health problems among infants and children, and by raising the profile of mental health services available for this age group.

Information on children's mental health provided to community members by early childhood educators, teachers, health professionals and other workers should be consistent across all government and non-government services. To make this possible, all workers need training on clear messages and resources to promote these.

An Australian collaboration between the Telethon Kids Institute and the Minderoo Foundation (CoLab) argues that messages for the general community should define mental health in terms of positive states of wellbeing that can be promoted, rather than as mental health problems and illnesses that must be addressed.[162] CoLab recommends reframing messages to the public in a way that emphasises positive mental health to help kids thrive, fairness, and 'what all children need'. [162, 163]

A report developed by The Workshop for the Child Wellbeing Unit of the New Zealand Department of the Prime Minister and Cabinet recommended the following approach:[26]

- Use a 'resilience' frame where you don't talk about toxic stress without also explaining people's capacity for resilience. This helps people to understand that negative experiences in childhood do not necessarily lead to negative outcomes later on and avoids the thinking that the damage from these experiences in childhood is irreversible.
- Frame the context in which parenting is taking place so that parents do not feel guilty for the impact that external factors and stressors have on their ability

to responsively parent ... what helps is to explain the external conditions that affect outcomes first and then tell stories about individual autonomy. This frame helps people move away from the idea that responsive parenting is simply a matter of good choices.

Appendix 1. Reports and resources

Evidence reviews

Sahle B, Reavley N, Morgan A, et al. [Communication brief: Summary of interventions to prevent adverse childhood experiences and reduce their negative impact on children's mental health: An evidence based review](#). Melbourne: Centre of Research Excellence in Childhood Adversity and Mental Health; 2020.

[The Early Intervention Foundation Guidebook](#). 2018.

Australian reports and resources

Australian Government. [The National Children's Mental Health and Wellbeing Strategy](#). 2021: Available from: .

Australian Government Productivity Commission. [Mental health. Report no. 95](#). Canberra: Australian Government; 2020.

Australian Government Institute of Family Studies library database: [Infant and child mental health](#)

CoLab - Collaborate for Kids [resources](#)

Emerging Minds [resource library](#)

NSW Ministry of Health. [The first 2000 days. Conception to age 5. Framework](#). Sydney; NSW Government: 2019

Parkinson, S, Gunawan, A, Lewig, K, Flaherty, R & Arney, F [Improving service responses to vulnerable families during pregnancy and infancy: A report to the Australian Government Department of Social Services](#) Adelaide; Australian Centre for Child Protection, University of South Australia: 2017.

State of Victoria, Royal Commission into Victoria's Mental Health System, [Final Report](#). Parl Paper No 202 (2012 - 2021)

[Victoria State Government Department of Health and Human Services. Roadmap for Reform: strong families, safe children. Priority Setting Plan. Victorian Government; Melbourne: 2021-24.](#)

Aotearoa-New Zealand reports and resources

[Clinical Network for Child Protection](#) (Aotearoa New Zealand)

Duncanson M, Oben G, Adams J, et al. [Health and wellbeing of under-15 year olds in Aotearoa 2018](#). Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago; 2019.

Government Inquiry into Mental Health and Addiction. [He Ara Oranga : Report of the Government Inquiry into Mental Health and Addiction 2018](#).

The New Zealand [Child and Youth Wellbeing Strategy](#)

Aotearoa-New Zealand [Family violence & sexual violence work programme](#)

Aotearoa-New Zealand [Royal Commission of Inquiry into Abuse in Care](#) [ongoing]

[Supporting parents, healthy children](#). Wellington; Ministry of Health: 2015.

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