

# Melbourne Children's Campus Mental Health Strategy

## Submission to the Federal Parliamentary Inquiry into the relationship between domestic, family and sexual violence and suicide

*Jan 2026*



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# Acknowledgments

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*This document was developed on the lands of the Wurundjeri Woi-wurrung and Boon Wurrung peoples of the Kulin Nation in Naarm, Melbourne. The Campus Mental Health Strategy recognises all First Nations Australians, their cultural heritage, beliefs, and relationships to Country and acknowledges the significant impact of colonisation, intergenerational trauma, and systemic disadvantage that affects mental health outcomes for Aboriginal and Torres Strait Islander communities across Australia.*

The Campus Mental Health Strategy acknowledge the individual and collective expertise of all people with lived and living experiences of mental health challenges and recovery. We acknowledge the activists and advocates who came before us, and built the foundations upon which we are privileged to be working from today. We also acknowledge the emerging leaders with lived and living experiences, especially our young people and those with intersectional identities. We acknowledge importance of centring lived and living expertise and ensuring that there is "nothing about us without us."

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## Melbourne Children’s Campus Mental Health Strategy

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**“Our vision is that all infants, children, young people, and their families have access to high-quality, equitable, consistent and preventative mental health care where and when they need it to achieve sustained, optimised developmental, health and wellbeing outcomes.”**

## Who are we?

This submission presents the Melbourne Children’s Campus Mental Health Strategy (the strategy) and its outputs as a blueprint for other Australian paediatric hospitals to better integrate evidence into workforce education and clinical care that is child and family-centred, responding to the mental health and wellbeing needs of children.

The strategy unites partners of the Melbourne Children’s Campus, including The Royal Children’s Hospital (RCH), Murdoch Children’s Research Institute and the University of Melbourne Department of Paediatrics. By working together, our clinically driven research informs workforce education and training fostering evidence-informed mental health care.

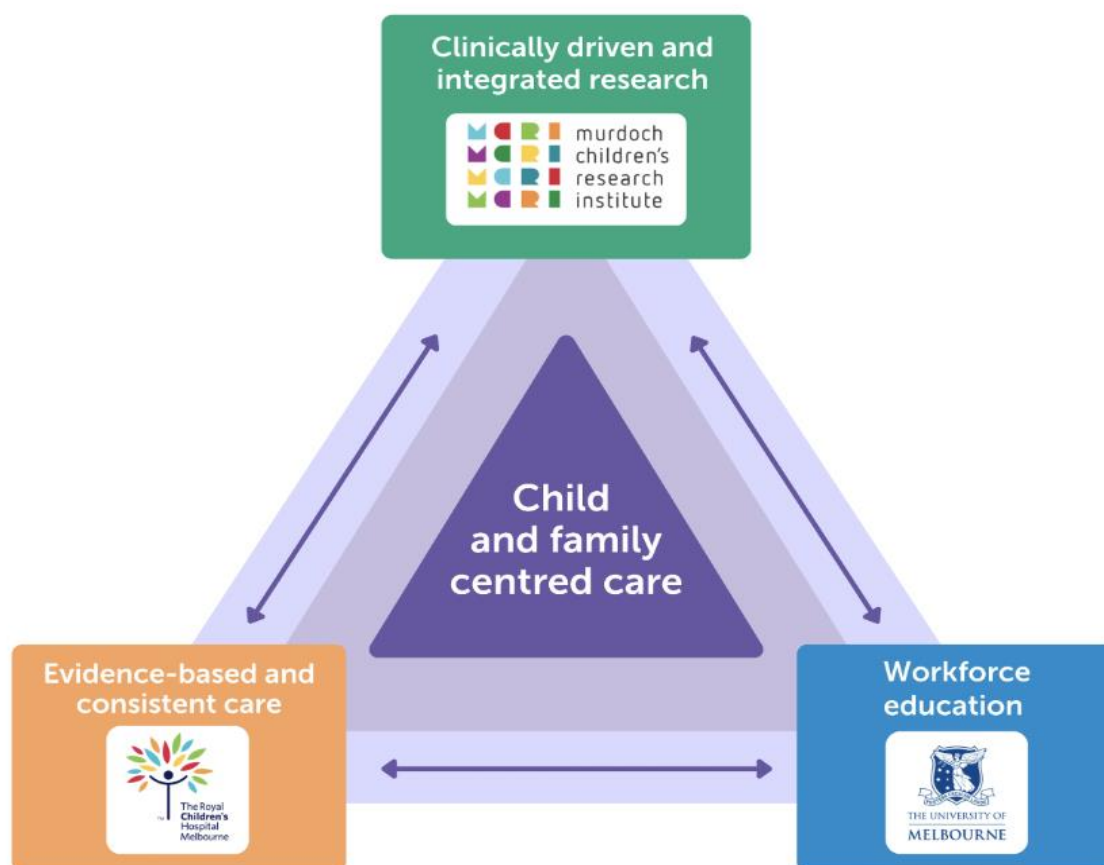


Figure 1: How the strategy brings campus partners together

The strategy works to ensure that all infants, children, and young people and their families attending RCH and the surrounding community have access to high quality, equitable and consistent preventative and early mental health care and support.

**THE STRATEGY delivers integrated mental health research and education to:**

Melbourne Children’s Campus Submission to the Federal Parliamentary Inquiry into the relationship between domestic, family and sexual violence and suicide

- Embed Trauma-Informed Preventative Care into RCH, reducing paediatric medical traumatic stress
- Supports clinicians and non-clinical staff towards delivering evidence-informed mental health care
- Ensure children and their family are at the centre of care, including parents/carers and siblings
- Inform children, young people, parents and carers

## Our Approach

Over 5 years (2021-2026), the strategy has developed, tested, and evaluated a systems-wide approach to ensure evidence-based, trauma-informed, family-centred mental health care is embedded into routine clinical care, education, and research.

The strategy has done this by:

1. Engaging campus leaders to support oversight, advocacy and sustainability
2. Mapping existing programs and resources to identify gaps and opportunities
3. Analysing campus stakeholders and establishing engagement structures, including advisory and working groups, communication mechanisms, and a Lived Experience Advisor Network
4. Co-designing activities and resources in partnership with stakeholders and people with lived experience
5. Piloting initiatives and evaluating their feasibility, acceptability, and impact

A strategic approach to infant, child, and adolescent mental health

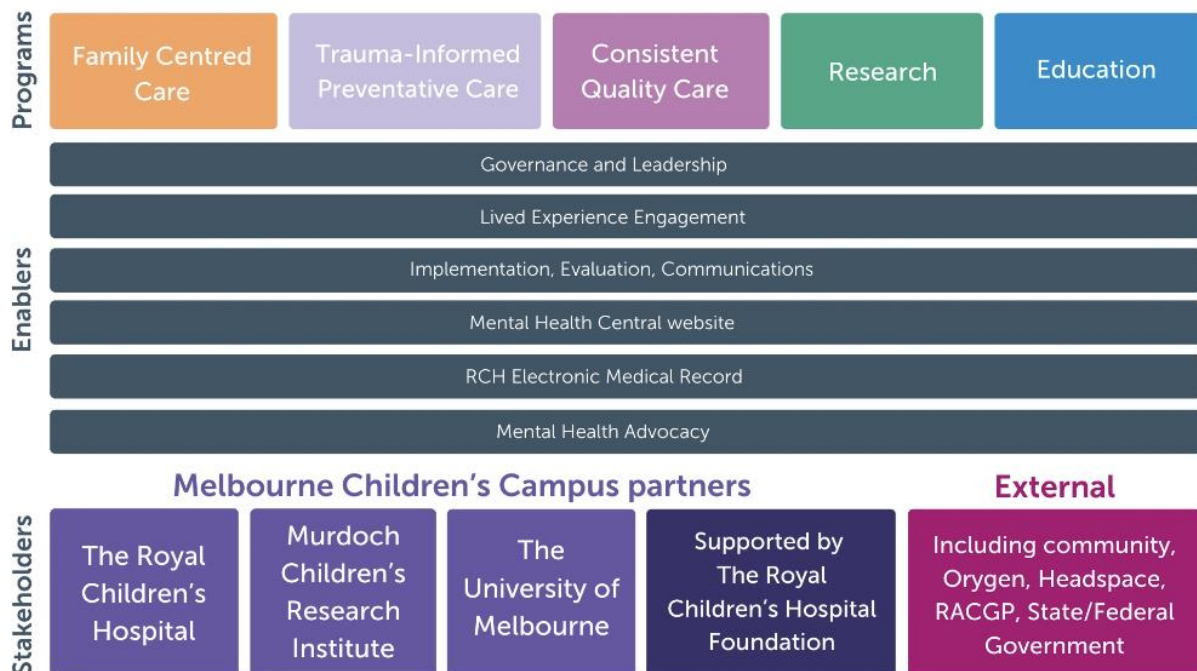


Figure two: the Strategy on a page

# Executive summary

This submission draws on the **Australia first Evidence-based Clinical Practice Guideline on Suicide and Non-suicidal Self-Injury (NSSI) in Children and Adolescents** (Melbourne Children’s Suicide and Non-suicidal Self-injury Guideline Development Group, 2026) and the accompanying Technical Evidence Report (Misso, 2026) developed to address the critical intersection between domestic, family and sexual violence (DFSV) and suicide risk in children and adolescents. Exposure to family violence, trauma, coercive control and cumulative adversity is a central developmental driver of suicidal ideation, suicide attempts, and NSSI behaviours in childhood and adolescence, particularly where violence co-occurs with parental mental illness, substance use, housing instability and social disadvantage.

While evidence clearly establishes DFSV as a fundamental public health determinant of child and youth suicide risk, current service systems remain fragmented and crisis-driven, often responding to acute harm without coordinated early intervention, trauma-informed care, continuity of support or meaningful engagement of families and lived experience voices (Productivity Commission, 2025). Together, this evidence and system gaps point to a set of integrated reform priorities required to strengthen prevention, early identification, recovery and long-term outcomes for children and adolescents affected by DFSV. With this in mind, we propose the following **five key recommendations**, organised across three reform themes.

## Recommendations

### Suicide and non-suicidal self-injury in children experiencing DFSV

1. Recognise DFSV exposure as a major determinant of suicide and NSSI risk among children and adolescents within national frameworks and policy.

### Training and development of the workforce

2. Implement Trauma-Informed Preventative Care across paediatric health, mental health and allied child services.
3. Embed family-centred care approaches and wellbeing assessment tools to support early identification and holistic intervention.
4. Promote clinical research and guideline development into mental health and suicide/NSSI in future government strategies and grant funding

### Lived experience engagement

5. Develop and engage lived-experience leadership and co-production in policy development, clinical governance, service design, and system reform.

Recommendation and related Terms of Reference	1	2	3	4	5	6
1. Recognise DFSV exposure as a determinant of suicide & NSSI risk	✓			✓		✓
2. Implement Trauma-Informed Preventative Care			✓		✓	
3. Embed family-centred care and wellbeing tools			✓		✓	✓
4. Promote clinical research and guideline development			✓		✓	✓
5. Engage lived experience leadership and co-production			✓			✓

# Domestic, family and sexual violence are risk factors for suicide and NSSI amongst children and young people

Domestic, family and sexual violence (DFSV) is a significant and well-established risk factor for NSSI, suicidal ideation, and suicide attempts in children and young people.

As part of the development of an evidence-based clinical practice guideline for suicide and NSSI in children and adolescents, a systematic evidence review conducted in April 2025 examined risk factors for NSSI, suicidal ideation, and suicide attempts in children and adolescents aged 0–19 years. This review identified 18 articles that met the selection criteria for full-text review and were extracted (Misso, 2026). Risk factors identified with moderate certainty that are **directly associated with exposure to DFSV or its downstream impacts include maltreatment or abuse, parental incarceration, parental aggression, family history of mental illness or suicide, and contact with Child Protection Services or out-of-home care**. The search also identified neurodivergence, mental illness, bullying or cyber-bullying, and exposure to peer suicide or self-harm as risk factors for suicide and NSSI in children and young people (Misso, 2026).

Exposure to DFSV undermines a child’s sense of safety, attachment, and emotional regulation, and is strongly associated with trauma, chronic stress, and developmental disruption. **These effects increase vulnerability to self-harm and suicidal behaviours**, particularly when exposure is prolonged or co-occurs with other adverse childhood experiences.

Recognising DFSV as a core risk factor for suicide and NSSI in children and young people is essential for effective prevention. Early identification of suicide risk requires trauma-informed, system-wide responses across health, education, child protection, and community systems, and early identification and support for children and families affected by violence (Melbourne Children’s Suicide and Non-suicidal Self-injury Guideline Development Group, 2026). Explicit recognition of DFSV within suicide and self-harm prevention frameworks is critical to addressing the underlying drivers of risk and improving outcomes for vulnerable children and young people.

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***Recommendation one: Recognise DFSV exposure as a major determinant of suicide and NSSI risk among children and adolescents within national frameworks and policy.***

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# Workforce training for health and allied professionals should be trauma informed, family centred and consistent to holistically address suicide and NSSI in children and families

A skilled, confident and trauma-informed workforce is essential to effective suicide prevention and response for children and adolescents exposed to DFSV. Evidence shows that most community-based **mental health care for children is delivered by generalist professionals, particularly general practitioners (35%) and paediatricians (21%), while only a small proportion of children access specialist psychiatric services (7.1%)** (Johnson et al., 2016). Psychologists, nurses and allied health professionals therefore play a central role in early identification, assessment and ongoing management of suicide risk and trauma-related presentations.

Despite this critical role, **many professionals report limited mental health education and insufficient training to respond to the complexity of children's mental health needs.** This deficit is even more distinct when presentations are shaped by trauma and family violence (Withiel et al., 2021). Studies consistently identify gaps in knowledge, confidence and competency across clinical and non-clinical workforces (Alisic et al., 2014; Alisic et al., 2016; Hoysted et al., 2017; Moss et al., 2019). **In cases of suicide and NSSI amongst children and young people, confidence amongst healthcare workers is even more limited and varies significantly** (Osborne et al., 2023; Olsen et al., 2025). If not addressed, these gaps will continue to contribute to inconsistent care, missed opportunities for early intervention, and increased workforce burnout.

The strategy has addressed workforce competency gaps through targeted education packages for generalist and specialist clinicians and non-clinical staff (CMHS, 2024). These programs strengthen mental health literacy, trauma-informed engagement, and consistent, evidence-based responses, while embedding family-centred care principles that position families as partners in assessment, planning, and recovery.

A core initiative has been Trauma-Informed Preventative Care (TIPC) training, which equips staff to recognise the impacts of trauma and adopt trauma-informed approaches that prevent retraumatisation of children, families, and staff (Elliot and Gibroski, 2024). Delivered through multimodal learning approaches incorporating video, audio, and infographic content, TIPC training has demonstrated statistically significant improvements in participants' knowledge and competence in trauma-informed practice.

Complementing this, the Family-centred care model is an approach to whole-child health and wellbeing that considers and supports the child's environment, including families and carers. Within this model, the Children's Wellbeing Continuum provides a strengths-based assessment tool co-designed for use by families, educators and clinicians and was used to

inform the initiative (The Centre for Community Child Health, 2022). It provides a shared language and framework for identifying, monitoring, and responding to variations in children’s social and emotional well-being over time. Further, this framework supports parents and carers in understanding and communicating their own emotions. By embedding this tool into routine practice, the workforce gains a structured mechanism to facilitate early recognition of distress and behavioural changes that can signal emerging suicide or self-injury risk, particularly in the context of family violence and trauma exposure.



Figure three: the Wellbeing Continuum

The strategy has also developed evidence-based Clinical Practice Guidelines to reduce care variation and strengthen clinical consistency across service systems. *The Evidence-based Clinical Practice Guideline for Anxiety in Children and Young People*, endorsed by the Royal Australian College of General Practitioners (RACGP), was published in 2024 and was successfully disseminated across Australia and globally (Melbourne Children’s, 2024).

Building on this and a known lack of clinical practice guidance in the area (McKinlay et al., 2025), the strategy developed and published Australia’s first evidence-based clinical practice guideline on suicide and NSSI in children and adolescents on January 29, 2026. *The Suicide and Non-suicidal Self-injury in Children and Adolescents; Evidence based clinical Practice Guideline* provides **clear recommendations for trauma-informed identification, assessment, management to support clinicians and other professionals to deliver consistent, high-quality care to children and adolescents experiencing suicide and NSSI, including those whose presentations are shaped by DFSV-related trauma** (Melbourne Children’s Suicide and Non-suicidal Self-injury Guideline Development Group, 2026).

An enabled workforce that is sufficiently upskilled is essential to understanding and responding effectively to children’s mental health and wellbeing in DFSV contexts. This requires structured, evidence-based education and support that build trauma-informed practice capabilities, strengthen risk assessment, and support family-centred care.

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**Recommendation 2: Implement Trauma-Informed Preventative Care across paediatric health, mental health and allied child services.**

**Recommendation 3: Embed family-centred care approaches and wellbeing assessment tools to support early identification and holistic intervention.**

**Recommendation 4: Promote clinical research and guideline development into mental health and suicide/NSSI in future government strategies and grant funding**

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## Lived experience engagement, especially from DFSV victim-survivors, is crucial for effective policy and clinical practice

The knowledge and expertise of people with lived and living experience of mental health challenges are essential to maintaining high-quality mental health services, programs, and research, particularly in the context of trauma, family violence and suicide prevention for children and adolescents. Lived-experience perspectives provide critical insights into service barriers, help-seeking behaviours, and recovery pathways that are often overlooked in traditional service design and policy development.

The strategy embeds lived-experience leadership through the development of a comprehensive Lived and Living Experience Engagement Strategy. This framework ensures collaborative, consistent, remunerated, and supported engagement of people whose lived experience improves health services and research. The strategy has established a diverse network of over 1,300 Lived Experience Advisors representing a wide range of lived experiences and intersectional areas and has engaged more than 840 individuals in 75 activities and roles, including advisory bodies, focus groups, and lived experience storytelling initiatives (CMHS, 2019).

This active, structured approach demonstrates the value of lived experience in strengthening clinical excellence and rigorous research. Co-design, the preferred engagement model, has enhanced knowledge sharing and improved capacity building for both services and lived-experience participants (Roper et al., 2018). **In the context of DFSV and suicide prevention, co-produced approaches ensure that care pathways, early intervention strategies, and community supports are grounded in real-world experiences of children, young people and families affected by DFSV and suicide.**

While lived experience engagement is recognised within the National Mental Health and Suicide Prevention Agreement (National Mental Health Commission, 2024), implementation remains inconsistent across child-serving systems. The strategy advocates a fundamental shift from tokenistic consultation toward meaningful co-production, fair remuneration, and embedded lived-experience leadership in clinical governance, service design, and policy reform. Embedding these principles across health, mental health and DFSV systems will create more accountable, collaborative and effective responses to suicide and non-suicidal self-injury among children and adolescents.

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***Recommendation 5: Engage and develop lived-experience leadership and co-production in policy development, clinical governance, service design, and system reform.***

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## Conclusions

This submission demonstrates that DFSV is a critical risk factor of suicide and NSSI among children and young people. Increased exposure to violence, trauma, and adversity fundamentally disrupts a child's development, emotional regulation and sense of safety, significantly increasing vulnerability to suicide and NSSI (Melbourne Children's Suicide and Non-suicidal Self-injury Guideline Development Group, 2026). Despite this, current service systems remain fragmented, crisis-driven and insufficiently equipped to provide coordinated, trauma-informed and family-centred prevention and early intervention (Productivity Commission, 2025).

The Melbourne Children's Campus Mental Health Strategy provides a practical, evidence-based blueprint for addressing these gaps. Through integrated research, workforce education, clinical guidelines, and lived-experience co-production, the Strategy has demonstrated how system-wide, trauma-informed, and family-centred approaches can be embedded in routine paediatric care, education, and research. Importantly, this work moves beyond individual clinical responses to strengthen prevention, early identification and consistency of care across health and allied child-serving systems.

The development of Australia's first evidence-based clinical practice guideline for suicide and NSSI in children and adolescents represents a critical national advance. Together with Trauma-Informed Preventative Care training, family-centred wellbeing tools and structured lived-experience leadership, these initiatives strengthen workforce capability, reduce variation in care, and support earlier, more holistic responses to children exposed to DFSV.

The evidence and implementation experience presented in this submission point to clear reform priorities. Recognising DFSV as a core driver of suicide and NSSI risk, investing in trauma-informed and family-centred workforce capability, embedding research and guideline development, and meaningfully engaging lived experience are essential to improving outcomes for vulnerable children and young people.

Without sustained, system-wide reform, opportunities for early intervention will continue to be missed, and preventable harm will persist. By adopting the recommendations outlined in this submission, governments have a clear opportunity to strengthen prevention, improve service coordination, and deliver safer, more effective and more compassionate responses for children and families affected by domestic, family and sexual violence.

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## Contact Details

The CMHS thanks the Parliamentary Inquiry team for the opportunity to provide this submission to the Inquiry. We would be pleased to provide further expert opinion to the Inquiry in any of the focus areas related to this submission. For more information, please contact us via our emails or visit our website <https://mentalhealth.melbournechildrens.com/>.

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