



executive summary

Evaluation Final Report

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Photo: VicHealth



Centre For Analysis of Educational Futures
FLINDERS UNIVERSITY 2009



AUSTRALIAN PRIMARY SCHOOLS
MENTAL HEALTH INITIATIVE

KidsMatter: the Australian Primary Schools Mental Health Initiative is developed in collaboration by the Australian Government Department of Health and Ageing, *beyondblue: the national depression initiative*, the Australian Psychological Society, Principals Australia, with support by Australian Rotary Health.

KidsMatter information and resources (including electronic copies of this report) are available from www.kidsmatter.edu.au. Hard copies of this report can be ordered from www.beyondblue.org.au (click [Get Information](#)).

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Foreword

I am pleased to be writing the foreword to this report on the evaluation of the national pilot of *KidsMatter: the Australian Primary Schools Mental Health Initiative*. The evaluation shows this initiative has worked wonderfully well - and I'm thrilled that it will be extended to more primary schools and adapted for pre-school children Australia wide.

In participating schools, the number of mental health difficulties in students diminished and overall, children experienced improved mental health and well-being.

These findings – together with the positive response KidsMatter has received from school communities across Australia – has convinced both the Australian Government and *beyondblue* of the need to continue to support this valuable initiative.

Our children are our future. By focusing on their well-being in pre-schools and primary schools, as they're growing up, they'll understand that good *mental* health is just as important as good *physical* health.

We know KidsMatter in schools helps to make kids resilient and gives them the tools they need to deal with problems. We hope they can build on this strong foundation through adolescence and into adulthood.

Children who feel good about themselves and who have good mental health are in a better position to enjoy and benefit from friendships, family relationships and learning opportunities.

On the other hand, children who don't feel good about themselves can have a hard time at school in both the playground and the classroom. If the children's problems aren't addressed early and the problems persist – this could lead to them having ongoing difficulties and fewer opportunities as they mature. The good news is these children can be helped, particularly if we recognise and address their problems early.

KidsMatter was developed to support the mental health and well-being of Australian children by helping schools to implement evidence-based mental health promotion, prevention and early-intervention strategies.

KidsMatter was strengthened by a very successful collaboration between *beyondblue: the national depression initiative*, the Australian Government Department of Health and Ageing, the Australian Psychological Society, Principals Australia, and Australian Rotary Health.

I commend the authors of this report from the Evaluation consortium led by the Centre for the Analysis of Educational Futures at Flinders University, which included staff from The University of South Australia and the Department of Education and Children's Services, South Australia.

Most of all, my congratulations and thanks go to the *children, parents and staff* of the 101 schools who participated in the KidsMatter pilot.

This is a fantastic initiative – a world-first by Australia – for which I thank everyone involved and I urge all states and territories to invest in their kids' futures by embracing KidsMatter.



The Hon. Jeff Kennett AC

Chairman

beyondblue: the national depression initiative

November 2009

KidsMatter Executive Summary

“What KidsMatter does is it actually introduces the notion that social and mental health wellbeing is important at the school level. It actually says to teachers and staff at schools ... that ... you can actually do it, and this is how you go about it. This is a model for you to be able to do this and you’ll be able to have some input into it and be able to participate. So KidsMatter, I think the importance of it, is changing the thinking of teachers – that they actually have a role to play in children’s social and emotional wellbeing ... Although they might not be a trained mental health professional, with the resources that KidsMatter provide, they are able to provide guidance as to where they may get that information.” *Counsellor School 9*

The KidsMatter Initiative

KidsMatter (KM) is an Australian national primary school mental health promotion, prevention and early intervention initiative. KM was developed in collaboration with the Australian Government Department of Health and Ageing, *beyondblue: the national depression initiative*, the Australian Psychological Society, and Principals Australia, and was supported by the Australian Rotary Health Research Fund.

KidsMatter uses a whole-school approach. It provides schools with a framework, an implementation process, and key resources to develop and implement evidence-based mental health promotion, prevention and early intervention strategies. The KM framework consists of four key areas, designated as the KM components:

1. Positive school community
2. Social and Emotional Learning for students
3. Parenting support and education
4. Early intervention for students experiencing mental health difficulties.

KidsMatter aims to:

- improve the mental health and well-being of primary school students
- reduce mental health difficulties amongst students
- achieve greater support for students experiencing mental health difficulties.

KidsMatter impact overview

“[KidsMatter] has changed school culture, I think. It’s changed the way the school views mental health. It’s given a greater awareness, but it’s also changed the way, I think, people relate to one another – particularly the students, and the way the classrooms operate.” *Principal School 9*

There were positive changes to schools, teachers, parents/caregivers¹, and children associated with KM over the two year trial.

- There was evidence of change related to all four components of the KM framework.
- KidsMatter was associated with statistically and practically significant² improvement in students’ measured mental health, in terms of both reduced mental health difficulties and increased mental health strengths.
- The impact of KM was more apparent for students who were rated as having higher levels of mental health difficulties at the start of the trial.
- There was substantial similarity in the findings for schools formally involved in KM for one year and for schools formally involved over two years. However, there were some measures that showed stronger effects in the schools involved in KM for two years.

Background to the KidsMatter Evaluation

A Pilot Phase of KM was trialled in 100³ schools across Australia during 2007–2008. Fifty of the schools ran KM during the 2007 and 2008 school years. The remaining schools undertook KM during the 2008 school year. A consortium based in the Centre for Analysis of Educational Futures at Flinders University undertook an evaluation of the two-year trial.

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1 For simplicity, the term ‘parent’ rather than ‘parent or caregiver’ is used throughout this report, but is intended to be inclusive of both parents and caregivers.

2 The more rigorous significance level of 0.01 was chosen, to take into account multiple comparisons. Effect size was based on a regression coefficient equivalent to a partial correlation with 0.10, 0.24, and 0.37 as indicative of the cut points between very small, small, medium and large, respectively (Kirk, 1996). Small, medium and large effect sizes indicate changes that are of practical significance. In each case these reported practical effect sizes were associated with statistical significance.

3 The trial of KM was originally intended for 101 schools, but one school did not participate in the evaluation due to the challenges of a high proportion of transient students in a longitudinal study.

The evaluation examined the impact of KM on schools, teachers, parents and students. Teachers and parents of students (target age of 10 years) were surveyed during 2007 and 2008. Most items on the questionnaire required responses on a 7-point Likert scale from 'strongly disagree' (1) to 'strongly agree' (7). Special emphasis was placed on the impact of KM on student mental health. Mental health was measured to include both strengths and difficulties, with the main measure being the internationally used Strengths and Difficulties Questionnaire (SDQ), designed by Goodman (2005).

The surveys covered student mental health, engagement with, and implementation of KM, and influences on schools, teachers, parents and students. Survey responses were gathered on four occasions from teachers and on three occasions from parents, for up to 76 students per school. The first survey was completed by the parents and teachers of 4980 students.

The information available in the evaluation also included qualitative data provided in:

- reports from KM Project Officers who worked with each of the Pilot schools in the implementation of KM
- interviews and focus group discussions conducted with school leaders, teachers, parents and students in 10 schools in the latter part the KM trial
- summaries of the processes and effects of KM within their schools provided by principals and KM action team leaders at the end of the trial.

Statements about impact and change over time generated from the surveys are based on quantitative analyses and refer to results that are statistically significant and also of practical significance. Findings from the analysis of qualitative data following analysis in relation to the main themes and requirements of the evaluation are also presented at relevant points.

Impact of KidsMatter on schools and teachers

In general, schools adopted KM and actively worked at its implementation.

- Schools, teachers and parents increasingly became engaged with KM. This increased engagement was statistically significant and represented a large practical effect size. The increased engagement is illustrated by the fact that, at the start of the evaluation 35% of teachers strongly agreed (scored 6 or 7) that schools were engaged with KM, whereas by the end of the evaluation, 57% of teachers made such ratings. That is, 22% more teachers strongly agreed.
- By the end of the evaluation, 26% more teachers strongly agreed that schools were using the '7-Step' implementation process.
- Over the course of the trial, most progress was made on implementing Component 2: Social and Emotional Learning for students, and least progress was made on Component 3: Parenting Support and Education and Component 4: Early intervention for students.

A closer examination of the data revealed differences in the degree of implementation across schools. According to Project Officers' reports, high implementation schools:

- paid more attention to the prescribed 7-Step implementation process
- displayed a higher level of involvement of all stakeholders, including the active involvement of the school leadership team.

Although there were some difficulties and barriers to the implementation of KM, such as lack of available time in school timetables, there were positive reports about the impact of KM from stakeholders, including effects such as:

- facilitating the placement of mental health as an issue onto schools' agenda
- providing a conceptual framework for considering mental health issues
- providing a common language that enabled school communities to work on these issues
- making an impact on school culture, which facilitated the raising of issues related to mental health and child development.

KidsMatter professional development

Teachers were generally positive about the professional development delivered in KM. The effectiveness of the PD assessed at the end of the trial was highlighted by the finding that 60% of the teachers strongly agreed that the professional development had increased their commitment to promoting student wellbeing, and better equipped the school to address the four components.

The four KidsMatter Components

A major emphasis in KM was on the four components of the framework as the foundation for effecting change in student mental health. There was evidence of improvement in schools' performance associated with each component, although not all components improved to the same extent. There was more evidence of positive change in the ratings from teachers than in the ratings from parents.

Component 1: Positive school community. Parents and teachers provided high ratings for their school's performance on Component 1 at the start of KM, and there was little evidence of significant change in ratings for this component over the two years. At the start of the trial, approximately 63% of parents and teachers strongly agreed that their school was committed to developing a sense of belonging and connectedness for members of the school community. This level of rating for school commitment was maintained throughout the two years.

However, the interview and focus group data showed that the KM emphasis on positive school community appeared to strengthen and reinvigorate this component in the schools:

"Where I wanted to bring this focus in terms of parent and community was very much creating opportunities for parents and carers to come into our school for a variety of reasons. The most powerful way to do that was to invite them to come and work alongside their children in an activity linked strongly to curriculum ... The parents and carers are invited into our school for a variety of different reasons, all of them connected to KidsMatter in some way." Principal School 1

Component 2: Social emotional learning (SEL). Over the two years of KM, 19% more teachers strongly agreed that their school was performing well on the teaching of social and emotional skills for students.

Component 3: Parenting support and education. Compared with ratings at Time 1, by the end of the trial 7% more parents strongly agreed that KM had an effect upon their school's performance in providing parenting support and education. The comparable figure for teacher ratings was higher, with 22% more teachers strongly agreeing at the end of the trial that the school provided parenting support and education.

Component 4: Early intervention for students experiencing mental health difficulties. Parents' and teachers' views differed with respect to this component. The number of parents who strongly agreed to the school's level of early intervention (namely how effective their school was at supporting students who were experiencing mental health difficulties) did not change across the two year trial. However, by the end of the trial, 10% more teachers strongly agreed that their school was effective in providing early intervention. Data collected from the interviews indicated that schools prioritised their work on the four components, and that Component 4 appeared to be the last that received attention.

Teachers' knowledge, competence and confidence

Across the two-year trial there were increases in the teachers' ratings of their knowledge, competence and confidence with respect to teaching students about social and emotional competencies. From questionnaires collected at Time 4, compared to Time 1:

- 14% more teachers strongly agreed that they knew how to help their students to develop social and emotional competencies
- 8% more teachers strongly agreed that the school staff, as a whole, acted to help students to develop social and emotional competencies
- 16% more teachers strongly agreed that their teaching programs helped students to develop social and emotional competencies.

In addition, 11% more teachers strongly agreed that they felt effective in dealing with issues surrounding the mental health of students, such as being capable of identifying students experiencing social and emotional difficulties, and helping others to develop a sense of belonging in the school community.

Teacher attitudes about the importance of teaching students about social and emotional competencies were high at the start of KM and changed little over the course of the trial.

Impact of KidsMatter on family context

Interviews with parents revealed that they valued both the information provided by their school as part of Component 3: Parent support and education, and the strategies this information gave them for handling issues related to their children's mental health.

From Time 1 to Time 4, the surveys showed an increase in the number of parents who strongly agreed that:

- they had become more involved with the school as a result of KM (7% more parents strongly agreed)
- they had increased their capacity to help their children with social and emotional issues as a result of KM (11% more parents strongly agreed).

In addition, 10% more parents strongly agreed that, as a result of KM, the school's capacity to cater for their child's needs had improved. Furthermore, 22% more teachers strongly agreed with this statement.

However, findings from the parent questionnaire related to parenting knowledge and parenting styles show no evidence of change as a result of KM. In the first administration of surveys at the start of KM in 2007, parents already held strong efficacy beliefs about their parenting knowledge and gave high ratings to their use of positive parenting strategies. Their beliefs and ratings of positive parenting remained strong for the duration of KM.

Impact of KidsMatter on student competencies

Three kinds of impact on children were examined in the evaluation. The first concerned impact on student social and emotional competencies, the second was about schoolwork, and the third related to measures of student mental health.

Student social and emotional competencies

At the start of KM, 54% of parents and teachers indicated that students were performing well in areas of social and emotional competence, such as the ability of students to solve personal and social problems. By the end of the KM trial, there were 7% more parents and teachers who strongly agreed about the positive nature of students' social and emotional competencies.

Students' schoolwork

- During the two years of KM, over 90% of teachers consistently strongly agreed that “students who are socially and emotionally competent learn more at school”.
- Teachers' ratings of the positive impact of KM on students' schoolwork increased across the period of KM, with 14% more teachers strongly agreeing with the statement “KidsMatter has led to improvements in this student's school work” by the end of KM.

Impact of KidsMatter on student mental health

The central purpose of KM was to improve student mental health and well-being and to reduce mental health difficulties. The principal measure of student mental health difficulties used in the evaluation was the Total SDQ Difficulties score (Goodman, 2005) using parent and teacher ratings of the targeted students (up to 76) in each KM school. This total difficulties measure is the sum of scores on the SDQ subscales of Emotional Symptoms, Conduct Problems, Peer Problems and Hyperactivity. At the start of KM, the average Total SDQ Difficulties scores were low, being around a rating of 7 by teachers and a rating of 9 by parents. These scores are well within the range of 'normal' mental health on the SDQ scale, with a possible total score of 40 (high level of difficulties).

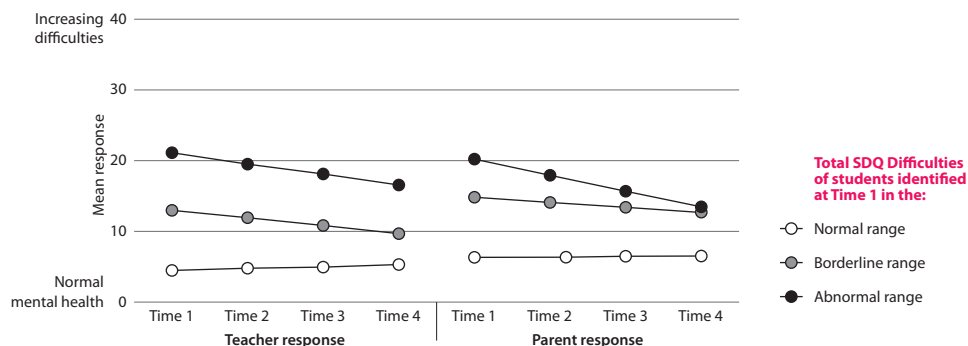
Reduction in Total SDQ Difficulties

On average across all students, the Total SDQ Difficulties score declined significantly over the period of KM, equivalent to a small effect size. This decline represents a practically significant overall reduction in mental health difficulties associated with the implementation of KM.

Reduction in SDQ difficulties for students in the normal, borderline and abnormal ranges

A further examination of changes in student mental health was based on Goodman's (2005) recommended cut-off points for categorising students into 'normal', 'borderline', and 'abnormal' ranges according to their Total SDQ Difficulties scores (using both parent and teacher ratings). Previous research suggested that about 80% of students score in the normal range, with about 10% of students scoring in each of the borderline and abnormal ranges respectively (Hayes, 2007). At the start of KM, 25% of the sampled students were classified within the borderline or abnormal ranges by teachers, and 23% by parents⁴. Change over time in SDQ Difficulties (Total score and subscale scores) was examined for students who were classified within the normal, borderline or abnormal ranges at the start of the trial. It was found that:

- There was a reduction in the Total SDQ Difficulties for students in the borderline and abnormal ranges across the period of the trial, with these reductions representing medium to large effect sizes, as presented in the following figure⁵.



- For students in the abnormal range, there were medium to large effect sizes associated with reductions in the mean scores for the SDQ subscales of Emotional Symptoms, Conduct Problems, Peer Problems and Hyperactivity.

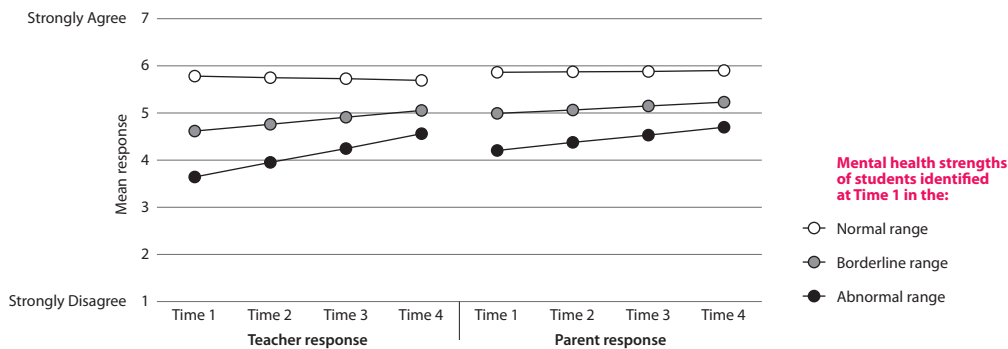
⁴ The higher percentage of students in the borderline and abnormal ranges in this evaluation reflects the sampling strategy of intentionally targeting students who may be exhibiting social, emotional or behavioural difficulties.

⁵ The plotted trajectories represent the results of hierarchical linear modeling analysis based on the student within schools regression line fitted to the available data across the four occasions.

- For students in the borderline range, there was a medium effect size for a reduction in the mean score for Hyperactivity, and small effect sizes for reductions for the other three subscales.

Improved mental health strengths

In addition to reductions in mental health difficulties on the SDQ and its subscales, students in the abnormal and borderline ranges showed significant improvements over the period of the KM trial on a scale designed to measure Mental Health Strengths. There were medium effect sizes for Mental Health Strengths for students in the abnormal range, and small effect sizes for students in the borderline range, as displayed in the following figure.



Furthermore, students in the abnormal and borderline ranges also improved significantly on a purpose-designed measure of social and emotional competencies over the period of the trial (abnormal group: medium and large effect sizes for improvement) (borderline group: small and medium effect sizes for improvement).

Change in the proportion of students in the normal, borderline and abnormal ranges

As an alternative way of considering changes in student mental health at the population level, the proportion of students who were identified within the normal, borderline or abnormal ranges according to the SDQ cut-off points was calculated for each of the four times of data collection. An improvement in overall student mental health would be indicated by a decrease in the proportion of students who were classified within either the abnormal or borderline ranges, and a corresponding increase in the proportion of students classified within the normal range. Based only on the Total SDQ Difficulties scores, and keeping parent and teacher reports separate, this analysis showed that the proportion of students scoring within the abnormal and borderline ranges was reduced by 4.5% according to ratings by teachers, and by 5.8% according to ratings by parents, across the period of KM. This reduction of students within the abnormal and borderline ranges was associated with a 5% increase in the proportion of students classified as being in the normal range. This represents a positive change for approximately 1 in 5 of the students who were originally in the abnormal and borderline ranges.

Classifying students using both mental health strengths and difficulties

“Mental Health is not simply the absence of mental disorder or illness, but also includes a positive state of mental well-being.” (World Health Organisation, 2004)

In order to take into account students’ mental health strengths as well as difficulties, and by bringing together parent and teacher reports, an expanded set of criteria were used to classify⁶ students into normal, borderline and abnormal ranges. The score ranges for these groups were formed from parent and teacher ratings of students on the Total SDQ Difficulties score, as well as from parent and teacher ratings of students on two purpose-designed measures, namely the Mental Health Strengths and the Mental Health Difficulties scales. The profile of each group according to their score on the three measures showed, as expected, that:

- students within the abnormal range were rated higher on difficulties and lower on strengths
- students within the normal range, were rated lower on difficulties and higher on strengths
- students within the borderline range displayed a profile that included some difficulties but also some strengths.

This alternative method of classification showed that at the start of KM 34% of students were classified into the borderline or abnormal ranges. By the end of the trial, this figure had reduced to 24%. As a consequence, 10% more students were classified into the normal range by the end of the trial. This represents a positive change for approximately 1 in 3 of the students who were originally in the abnormal and borderline ranges. One possible interpretation of this finding is that KM was associated with improved mental health scores of more students than suggested by the analysis that used the Total SDQ Difficulties classifications alone.

⁶ Students were classified based on three measures of mental health using Latent Class Analysis. This alternative method of classification was undertaken using Goodman’s SDQ cut-off points applied to each measure and therefore Goodman’s classification labels of normal, borderline and abnormal were retained to maintain consistency of wording in this report.

In particular, the classification of students using the expanded criteria showed a larger impact on students who were in the borderline range than suggested in the SDQ Difficulties analysis, possibly because KM was able to build upon students' existing strengths as well as reducing difficulties.

Furthermore, it is possible that the classification using the expanded criteria resulted in a more targeted recognition of students in the abnormal range. These students have an overall profile of high difficulties and low strengths based on the reports of both parents and teachers. It is expected that it is relatively more difficult to effect change in students with this type of profile.

Conclusions

“Look it really works. It can change school culture, which changes the way kids relate. It really does. By having that focus and by really thinking about how kids relate to one another; how the staff relate to the children and teaching them a set of relationship skills to help them cope. You can really make a profound difference in your school and in those children’s lives. ... I think that there has been a fairly profound effect and one of the best parts of KidsMatter I think it’s changed culture and focus within the school community.” *Principal School 9*

KidsMatter appears to have impacted upon schools in multiple ways, being associated with a systematic pattern of changes to schools, teachers, parents and students. These included changes associated with school culture and approaches to mental health difficulties, as well changes that served to strengthen protective factors within the school, family and child. Importantly, KM was associated with improvements in students' measured mental health, especially for students with higher existing levels of mental health difficulties.

“We’ve given a much stronger focus to our community, students and parents, being able to articulate emotions and stretch their language so they really have an understanding that there’s things much deeper than happy and sad, and that’s where we were before. So you hear a lot of people talking a lot more – and a lot more deeply – about where they are, how they’re feeling, how people’s actions affect their actions.” *Principal School 9*

It needs to be remembered that KM was a multi-faceted, population-based initiative using a whole-school approach. It was based on a conceptual framework, a prescribed implementation process and provision of key resources. Any explanation of possible changes in student mental health must consider all aspects of KM and its approach. It is most likely that the obtained changes in student mental health are due to KM rather than other factors such as student maturation.

The outcomes of the KM trial are consistent with an emerging body of national and international literature that a 'whole school' approach can be protective for students, promoting a positive shift in mental health for the whole school population, and helping to enhance academic and social competencies through more positive interactions between all members of the school community.

However, although there is evidence from the evaluation of the successful implementation of KM and of associated positive changes, the observed impacts varied in size and were not evident in all aspects of KM. Furthermore, evidence of potential limitations and of possibilities for increasing the effectiveness of KM also emerged. In particular:

- Stakeholders highlighted the importance of leadership in generating change – particularly transformative leadership which brings about change in attitudes, beliefs and behaviour in the school community.
- It was challenging for schools to find space for all four KM components in an already crowded curriculum. However, the fact that KM opened a niche in school timetables for issues related to student mental health is considered to be a key factor in the success of KM.
- As with all curriculum innovations, the sustainability of KM was raised as an issue, and as one School Principal noted, “we need to have really strong structures – the sustainable structures in place so that it continues, but time is a real factor”. In particular, it was argued that the maintenance of the support and resources provided to schools is necessary to ensure that KM is sustainable and continues to be effective.
- It was also apparent that the implementation of Components 3 and 4 presented challenges for many schools.

Although there were some variations in the pattern of findings for schools involved in KM for one year, and for schools involved over two years, the nature of the intervention makes it difficult to interpret or explain the variations. However, one clearly apparent factor was the development of expertise of the KM team in general and the KM Project officers in particular, during the first year. This meant that the roll-out of KM in Round 2 schools during 2008 benefited strongly, in terms of being able to access an expanding base of available knowledge and of resources generated from KM activities in Round 1 schools in 2007.

Recommendations

“This is not an initiative for poor schools with disadvantaged families, it’s an initiative for all children in primary schools and all types of schools.” *Principal School 5*

Taking account of the evaluation findings and subject to the recommendations below, the main recommendation is that the broad framework, processes and resources of KidsMatter be maintained as the basis for a national roll-out.

Note that we have interpreted the effects of KM as a total package, and have no basis for drawing conclusions if parts of the package were to be delivered independently.

The evaluation suggested a number of ways for improving the efficacy of KM. As a consequence, it is recommended that, *inter alia*, future development of KM:

1. Provide guidelines to schools that will enable them to enhance the quality of the KM implementation in a structured and sustained way. These might include procedures for sharing best practice about the ways exemplary schools have implemented KM and how common problems, such as changes in key staff can be addressed.
2. Examine the conceptual model and the interactions of the elements upon which KM is based. There is a need to specify further the nature of the risk and protective factors under the headings of School, Family and Child. In particular, the positioning of the broad concept of 'School', and within 'School', teachers' knowledge, competence and confidence, as risk or protective factors for student mental health, needs further clarification and elaboration.
3. Give further consideration to ways in which schools can increase the effectiveness of Component 3 (Parenting support and education). This could include further research into effective models of delivery for parenting support and education within population-based mental health interventions. The gathering of knowledge from schools about exemplary practice related to this Component is also recommended.
4. Strengthen Component 4 (Early intervention for students with mental health difficulties), through further professional development for teachers on this component, and further consideration of ways of building of stronger connections between external agencies and schools. This could include:
 - supplementing the existing professional development with respect to teachers' knowledge, competence and confidence for identifying students at risk
 - investigating the perspectives of both schools and external agencies about the difficulties schools experience in instigating and accessing referrals to such external agencies.
5. Consider ways to further support the commitment to, and active involvement of, school leaders in developing and maintaining KM in their school setting.
6. Consider how the professional development can be enhanced to better prepare schools and teachers to implement and engage with Components 3 and 4.
7. Attend to the differing manifestations of students' mental health in home and school settings, and the consequences of these setting-based differences for students, teachers and parents. This might include supplementing existing advice about ways for parents and teachers to share their concerns and strategies for assisting students at risk of, or experiencing mental health difficulties, so that compatible approaches can be implemented in home and school settings.
8. Consider how KidsMatter can be productively linked with other mental health initiatives in schools, such as the mandated National Safe Schools Framework or the Council of Australian Governments National Action Plan for Mental Health 2006-2011.

KidsMatter Partners thank the following school communities:

New South Wales

Brooke Avenue Public School
Curran Public School
Dubbo Public School
Elands Public School
King Park Public School
Northmead Public School
St Bernadette's Primary School
St John Fisher Catholic School
St. Columbas Primary School
St Joseph's School Schofields
Bexley Public School
Carramar Public School
Faulconbridge Public School
Harrington Street Public School
St Bede's Primary School
St Oliver's Primary School
St Mary's Catholic Primary School
Tahmoor Public School
St Patrick's Primary School

Victoria

Christ the King Primary School
Hastings Primary School
Monmia Primary School
Sacred Heart Primary School
Saint Joseph's
St Bernadette's Primary School
St. Christopher's School
St. Vincent de Paul Primary School
Tootgarook Primary School
Upper Ferntree Gully Primary School
St Mary's Primary School
Benalla Primary School
Corio Primary School
Lumen Christi
North Brunswick Primary School
Southvale Primary School
St Andrew's Catholic Primary School
St Anne's Primary School
St. Therese's Primary School
St. Louis De Montfort Primary

Queensland

Burdekin School Special School
Home Hill State School
Ithaca Creek State School
Labrador State School
Pomona State School
Sandy Strait State School
St Joseph's Stanthorpe
Cairns West State School
Wondai State School
Caloundra Primary School
Goondiwindi State Primary School
Mater Hospital Special School
Redlynch State School
Tallebudgera State School
The Willows State School
Unity College
Upper Mt Gravatt State School

Western Australia

Bull Creek Primary School
Holy Name School
Kinlock Primary School
Liwara Catholic Primary School
Settlers Primary School
St Simon Peter Catholic Primary School
Nulsen Primary School
Geraldton Grammar School
Hilton Primary School
Lance Holt School
Leeming Primary School
Rockingham Beach Primary School
Star of the Sea Catholic Primary School
Cooinda Primary School

South Australia

Woodville Primary School
Hamley Bridge Primary School
Hewett Primary School
Leigh Creek Area School and Marree Aboriginal School
East Torrens Primary School
St Aloysius College
Annesley College
Cobdogla Primary School
Elizabeth Park Schools
Munno Para Primary School
Open Access College
Roxby Downs Area School
Woodcroft Primary School

Tasmania

Distance Education Tasmania
Richmond Primary School
Waverley Primary School
Kempton Primary School
Lauderdale Primary School
Rocherlea Primary School

Australian Capital Territory

Turner Primary School
Trinity Christian School
Canberra Girls' Grammar Junior School
Aranda Primary
Gowrie Primary School
St Francis of Assisi Primary School

Northern Territory

Gray Primary School
Living Waters Lutheran School
Nhulunbuy Primary School
Howard Springs Primary School
Jingili Primary School
Sacred Heart Primary School



Photo: VicHealth

"The Australian Psychological Society is pleased to be a partner in the successful KidsMatter Primary Schools National Mental Health Initiative. KidsMatter Primary has been shown to improve the mental health outcomes for those children most at risk, and have flow on effects to the whole school community, including parents, carers and families. In addition, the initiative increases the mental health capacity of schools and upskills teachers so it benefits the health and wellbeing of children in the long term."

– Professor Lyn Littlefield OAM FAPS, Executive Director, Australian Psychological Society

"Principals Australia sincerely thank the school leaders, staff, students and families of the 100 participating schools whose commitment to KidsMatter Primary and its implementation over the two years of the pilot is to be commended. The positive changes that occurred for students, staff and families reflect the strength, flexibility and adaptability of the KidsMatter framework and resources and the professionalism and commitment of all involved."

– Susan Boucher, CEO, Principals Australia

"Australian Rotary Health was pleased to support KidsMatter by providing funds to assist implementing some components of the program. KidsMatter provided a great opportunity for Rotary Clubs, the business community and general community to become involved with their primary schools."

– Joy Gillett, CEO, Australian Rotary Health



Australian Government

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