“beyondblue is delighted to be part of the KidsMatter Early Childhood initiative. We want children to feel good about themselves, enjoy their school years and develop strong healthy friendships and family relationships. We believe this program has the capacity to give children a strong foundation on which to build resilience and good self-esteem, to carry them through adolescence and into adulthood with good mental health.

I would like to thank the early childhood and education services, the children and parents who participated in the pilot, for their contribution, and the other organisations involved in the KidsMatter Early Childhood collaboration: the Australian Government Department of Health and Ageing, the Australian Psychological Society and Early Childhood Australia.

This is a wonderful initiative and I urge all states and territories to invest in their kids’ futures by embracing KidsMatter Early Childhood.”

Kate Carnell AO, CEO, beyondblue

“The Australian Psychological Society is proud to be an integral partner in the successful pilot of the KidsMatter Early Childhood mental health initiative for children in early childhood education and care services. KidsMatter Early Childhood helps services and families to promote positive child development and has been proven to reduce social and emotional difficulties in children most at risk. In addition, the initiative was shown to increase the capacity of services and families to support children’s social and emotional development so it benefits the health and wellbeing of children in the long-term. The Australian Psychological Society also wishes to thank the early childhood education and care services and families participating in the pilot for their commitment to the initiative and to children’s mental health and wellbeing.”

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

“The KidsMatter Early Childhood initiative is the first time where specialist knowledge and expertise in mental health and early childhood has been brought together to deliver a project of such scope in the early childhood education and care sector. This project comes at a time when there is a whole of government focus, through the National Quality Framework, on ensuring high quality outcomes for children using early education and care services. The evaluation demonstrates that KidsMatter Early Childhood can have a significant role to play in the national mission to enhance the quality of early childhood education and care services. Early Childhood Australia would like to thank the children, families and staff of the participating early childhood education and care services for their substantial contribution to the outcomes of the initiative.”

Pam Cahir, CEO, Early Childhood Australia
KidsMatter Early Childhood
Executive Summary

KidsMatter stresses the importance of giving all children a supportive, caring environment in which to grow emotionally, socially and physically – making friendships that could last through to adulthood – along with a high quality education. (Staff, ST455) ¹

The KidsMatter Early Childhood (KMEC) initiative is a pilot study that has been implemented in a very diverse group of Australian early childhood services that provide education and care for young children of differing ages. These early childhood education and care services ² also operate in a policy environment that is concerned with reform and so is experiencing significant change. The design of future versions of the KMEC initiative needs to be mindful of the diverse and dynamic nature of the early childhood education field.

This pilot of the KMEC initiative has involved the enactment of a specific package of procedures and components and the findings of the evaluation presented here are associated with the implementation of that specific and total package.

The KidsMatter Early Childhood Initiative

KidsMatter Early Childhood is the Australian national early childhood mental health promotion, prevention and early intervention initiative specifically developed for early childhood services. It was trialled in 111 long day care services and preschools during 2010 and 2011. KMEC involves the people who have a significant influence on young children’s lives – parents, carers, families and early childhood educators, along with a range of community and health professionals – in making a positive difference to young children’s mental health and wellbeing during this important developmental period.

The KMEC initiative provides a framework to enable services to plan and implement evidence-based mental health promotion, prevention and early intervention strategies. These strategies aim to improve the mental health and wellbeing of children from birth to school age, reduce mental health difficulties among children, and achieve greater support for children experiencing mental health difficulties and their families.

KMEC uses a risk and protective factors framework to focus on four components, where early childhood services can strengthen the protective factors and minimise risk factors for children’s mental health and wellbeing. The four areas that comprise the core content of KMEC are, 1) Creating a sense of community, 2) Developing children’s social and emotional skills, 3) Working with parents and carers, and 4) Helping children who are experiencing mental health difficulties.

KidsMatter Facilitators

Early childhood education and care services participating in the KMEC trial were each supported by a state or territory Facilitator. Facilitators worked with services to implement the framework by delivering professional learning related to each of the four components in KMEC, and visited

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¹ This code de-identifies the participant and details are provided in the KMEC Technical Report.
² Throughout this report, the terms ‘services’ and ‘centres’ refers to early childhood education and care (ECEC) services.
individual services to assist and guide early childhood educators\(^3\) in identifying goals, strategies and resources to work through the services’ action plan. The KMEC professional learning presented at each service guided staff in the implementation of the framework to improve mental health outcomes for children. Staff had the opportunity to identify their services’ strengths and to establish strategies for continuous improvement.

In addition to Facilitator support, each KMEC pilot service was supplied with a range of evidence-based resources. These assisted services to develop their capacity for promoting early childhood mental health and wellbeing, and to respond to the mental health needs of the children within their care.

**Background to the KidsMatter Early Childhood Evaluation**

*beyondblue* contracted Flinders University to undertake the evaluation of the KMEC Pilot Phase. The evaluation involved a team of researchers and support personnel located in the Flinders University Centre for *Student Wellbeing and Prevention of Violence*. The evaluation depended critically on the support of staff, service leaders and KMEC Facilitators. The essential working relationships were facilitated by the use of an Evaluation website, to keep stakeholders up-to-date with the progress and requirements of the evaluation, and by the dedicated work of members of each service Leadership Team, who managed the delivery and return of evaluation questionnaires.

The evaluation used multiple methods (questionnaires, interviews, photo study, Facilitator reports), involved multiple participants associated with the 111 services (Service leadership, staff, parents, and KMEC Facilitators), and gathered detailed data on multiple occasions (including four questionnaire data collection occasions over the two-year pilot). In considering the findings from this evaluation it is important to note that the first data gathering point for the evaluation (Time 1) occurred about five months after the KMEC initiative was first introduced to services.

**Implementation quality**

A significant facet of this two-year evaluation study of KMEC involved the development of an Implementation Index. As reported by Durlak and DuPre (2008) in their review of the literature on published mental health prevention studies, only a minority of published studies have reported on implementation processes (5%-24%). The same authors concluded that “the magnitude of mean effect sizes are at least two to three times higher when programs are carefully implemented and free from serious implementation problems than when these circumstances are not present” (Durlak & DuPre, 2008, p.340). This highlights the critical nature of implementation quality. The Implementation Index developed for the purpose of this evaluation was based upon the initial work undertaken for the KidsMatter Primary Implementation Index (Dix et al., 2010; Slee et al., 2009), with additional refinement to suit features particular to KMEC. A range of factors were identified as facilitating the KMEC initiative and were used in the Implementation Index, including leadership, engagement with the initiative, support structures and links with external agencies. Application of the Index in the evaluation identified 54% of services as High Implementing, 32% of services as Moderately Implementing, and 14% of services as Low Implementing.

KMEC Facilitators reported three main factors as supporting effective implementation.

1. Leadership: where the leadership was strong and focussed on the initiative.
2. Staff engagement: where the staff were engaged and motivated regarding the initiative.

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\(^3\) The terms ‘staff’ and ‘educators’ are generally used to refer to early childhood education and care educators.
3. Staff commitment: where the staff had a strong belief in and commitment to enhancing the mental health of children.

The emphasis on leadership as critical for effective implementation suggests that it should be given greater attention in the KMEC conceptual model.

Facilitators also reported that a number of factors impeded implementation of the initiative.

1. Leadership: poor leadership, busy leadership, top down leadership.
2. Staffing matters: including staff qualifications, experience, high staff turnover.
3. Lack of commitment to KMEC: staff not understanding the Initiative.
4. External circumstances: working with a high proportion of families under stress or duress; having a high proportion of children with particular behavioural issues and community circumstances including the poor socio-economic background of the communities; high unemployment.

Impact of KidsMatter Early Childhood on services and staff

An important goal of the KMEC initiative is that it leads to increases in staff knowledge, competence and confidence in relation to supporting the development of children’s social and emotional skills and in supporting children with mental health difficulties. According to participants in the photo study, this objective was clearly realised. In interviews, staff described their deeper understanding of children’s social and emotional wellbeing as a result of their involvement with KMEC.

Through KidsMatter for me personally, it’s made me look deeper at the child, and like this particular little boy and like where he’s come from. It’s made me look deeper at children and perhaps wondering why, perhaps where they’ve come from, why they behave like they do.
(Staff, ST4S5)

Analysis of the questionnaire responses showed that a strong area of improvement across the two-year intervention involved significant positive changes in staff views regarding their knowledge of children’s mental health. This practically significant effect was found across both High and Low implementing services. However, staff in High implementing services reported feeling more self-efficacious in their ability to help young children experiencing mental health difficulties. In interviews, some educators noted that KMEC affected them personally and that the improvement in their knowledge also translated from work to home, including their relationships with their own families.

Impact of KidsMatter Early Childhood on families and parents

Yes building a community, you can’t work collaboratively I suppose with the parents if you haven’t built the relationship. And you have to work on that and start a relationship so that you can work with them ... I think there is a difference, but if you don’t establish that connection, why would they work with you and trust you.
(Staff, ST4S1)

Parents gave high ratings to their knowledge about parenting at the start of KMEC and this changed little over the period of the trial. Similarly, parents rated highly their self-efficacy as parents and this barely changed over the two-year intervention. However, the evaluation indicates that there are two areas in which there is scope in future versions of KMEC to generate greater impact on parents and families. First, there were very modest positive changes in relation to parental involvement with the services and with the components of KMEC over the course of the two-year intervention. Second, in relation to the impact of KMEC on parents’ and carers’ knowledge and understanding, there were again, relatively modest changes in ratings of the services’ work with parents and carers, generally. It is likely that the results presented in this
report, indicating limited impact of KMEC on family contexts, partly reflect the lower implementation progress made on Component 3 throughout KMEC.

In relation to staff and parent views about the services working with parents and carers, almost three-quarters of staff and two-thirds of parents at Time 1 strongly agreed (scored 6 or 7) about aspects of the service’s ability to work with parents and carers. By Time 4, staff views increased by 11% and parent views increased by 6%. These findings add weight to the need for greater attention being given to reviewing how services can best engage with parents in the KMEC model.

**Impact of KidsMatter Early Childhood on children**

The central purpose of KMEC is to improve young children’s mental health and wellbeing and to reduce mental health difficulties. In the evaluation, because of the very dynamic nature of children’s involvement in these services, not all children could be tracked across the whole of the period of the evaluation. In order to undertake appropriate analyses of change in child outcomes, these analyses were carried out with a subset of participants, those for whom data were available on three or four occasions. The children in this subset were typically younger, were in care longer, and were located in High Implementing services. That is, they were located in services in which both staff and parents were reporting significant improvements in the ability of services to address children’s social and emotional needs. Nevertheless this subset of children represents a very significant group for consideration in both this evaluation and in the wider research field.

**Better meeting the needs of children with difficulties**

Gauging staff ratings of the impact that KMEC had on achieving greater support and meeting the needs of children with social and emotional difficulties was an important focus of the evaluation. Approximately half the staff at Time 1 strongly agreed (scored 6 or 7) that KMEC had helped them to:

- better recognise children experiencing difficulties (54%),
- provide better care for children (56%), and
- improve links with professionals who can assist children experiencing difficulties (46%).

Overall, these aspects improved by Time 4 with 20% more staff, on average, strongly agreeing that KMEC had helped them better recognise children experiencing mental health difficulties.

**Improved staff-child closeness**

In the KMEC conceptual model (described in Chapter 2) children’s high-quality relationships serve a protective function that helps to build resilience against childhood risk factors. In this evaluation, interpersonal relationships between staff and children were assessed with the widely used Student-Teacher Relationship Scale (STRS, Pianta, 2001). Using the conflict and closeness dimensions of the STRS to assess staff-child relationships, there was improvement equivalent to a small effect size in reports of closeness between staff and children during the course of the evaluation.

**Improved child temperament**

Child temperament is part of the KMEC evaluation conceptual model. Temperament is considered to be related to the development of protective factors early in childhood, crucial for subsequent adjustment to life’s challenges and stresses, including for children’s mental health and wellbeing (Smart & Sanson, 2005; Sanson et al., 2009). Two findings relate to factors of temperament. Parents reported a reduction in children’s ‘reactivity’ and an increase in their
‘approachability’, these positive changes being rated as small effect sizes. These findings, however, must be interpreted in relationship to children’s developing maturity (Newman & Newman, 2012).

Reduced mental health difficulties

For this KMEC evaluation study, Goodman’s Strengths and Difficulties Questionnaire (SDQ: Goodman, 2005) for children 3-4 years old (UK Version) was selected as the main outcome measure of child mental health.

Across the period of the evaluation there was a reduction in the Total SDQ Difficulties scores for the small groups of children initially classified as being in the borderline and abnormal ranges on the SDQ, with these reductions representing medium and large effect sizes, according to staff, and small and large effect sizes, according to parents. The profiles of change across time are shown in the figure below. As expected, the profile for children rated in the normal range did not show significant change in mental health difficulties.

The figure also presents the percentage proportions of children identified by parents and staff as having SDQ scores within the borderline or abnormal ranges at Time 1 and by Time 4. Across the period of KMEC, there were 2.7% fewer children, according to staff, and 3.3% fewer children, according to parents, in the combined borderline and abnormal ranges. This reflects children whose SDQ scores had shifted from the abnormal and borderline ranges into the normal range. On average, this 3% increase in the proportion of children in the normal range of mental health as defined by the SDQ, represents an improvement for 1 in 30 of all children included in this study, or an improvement for 1 in 6 children in this study initially identified with mental health difficulties.

<table>
<thead>
<tr>
<th>Total Strengths and Difficulties</th>
<th>All</th>
<th>Borderline or Abnormal ranges</th>
<th>Improvement in the borderline and abnormal SDQ score ranges for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td></td>
<td>At Time 1</td>
<td>By Time 4</td>
</tr>
<tr>
<td>Staff rated</td>
<td>1423</td>
<td>17%</td>
<td>14%</td>
</tr>
<tr>
<td>2.7%</td>
<td></td>
<td>Approximately 1 in 6 children</td>
<td></td>
</tr>
<tr>
<td>Parent rated</td>
<td>385</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>3.3%</td>
<td></td>
<td>Approximately 1 in 4 children</td>
<td></td>
</tr>
</tbody>
</table>

These findings must be considered in relation to the limitations of the evaluation and in light of the known age-related SDQ ratings for children similar in age to those participating in the KMEC pilot. However, the findings reported here are based on an analytical procedure that includes a correction for the participating child’s age. Thus, the changes across time reported here are argued to be estimates of change, over and above, developmental changes due to ageing during the two-year evaluation.
Conclusions

Security, comfort, belonging and a space of calm, shared communication. This is what KidsMatter has meant to me. Thank you KidsMatter for leaving me with the understanding of the importance of creating caring communities and a safe harbour for our children. (Staff, ST4SS)

The KMEC initiative provides a framework to enable preschool and long day care services to plan and implement evidence-based mental health promotion, prevention and early intervention strategies. KMEC uses a risk and protective factors framework to focus on four components where early childhood services can strengthen the protective factors for children’s mental health and minimise the risk factors. Risk and protective factors may be identified within the four components in relation to factors such as: individual skills, needs and temperament; familial circumstances and relationships; early childhood settings; specific life events; and the social environment.

Underpinning the evaluation reported here is the significant consideration given to the implementation of the initiative. Domitrovich et al. (2008, p.64) have argued that in program evaluation it is important to develop information about, “discrepancy between what is planned and what is actually delivered when an intervention is conducted.” A key feature of this evaluation study was to address these concerns by developing a robust measure of implementation quality to account for the likelihood that not all services can implement KMEC to the same level of quality. By doing so, it strengthened our ability to associate significant changes in services over the two years with the impact of the KMEC initiative. Implementation quality was shown to be an important influence on outcomes. The development and use of an Implementation Index enabled the identification of just over half of the participating services as high on implementation with regard to fidelity, dosage and quality. The evaluation tested a number of other factors, such as socio-economic background, that may influence quality of implementation, but found that the main factor influencing this implementation quality was the percentage of single parent families in a service. More research is needed to understand better why this factor would have such an impact on implementation quality.

Overall, the outcomes of the KMEC trial are consistent with an emerging body of national and international research pointing to the positive effects of social and emotional programs on children’s mental health and well-being. A key element in the delivery of the KMEC pilot is professional learning. This was identified in the findings to have strengthened existing good practices, provided opportunities for raising staff awareness and building knowledge of children’s mental health strengths and difficulties, reduced stigma, and provided staff with a common language to promote communication about mental health and well-being. Particular note is made of the acclaim given to the Facilitators in the delivery of the professional learning by service staff. It is noted that further work is needed to understand better the long-term impact of professional learning on staff knowledge, attitudes and behaviour.

However, although there is evidence from the evaluation of the successful implementation of KMEC and of associated positive changes, it is noted that the observed impacts varied in size and were not evident in all aspects of KMEC.

Furthermore, evidence of potential limitations and of possibilities for increasing the effectiveness of KMEC also emerged including:

- the challenges posed by changes in leadership and staff in successfully implementing the initiative,
- the importance of motivating and engaging staff around the significance of young children’s mental health in the face of competing demands in an industry undergoing significant reform and change, and
• the challenge of increasing the level of involvement of parents and carers with the key processes and content of KMEC.

Finally, the sustainability of KMEC is a significant issue and in this regard it is relevant to note that the effects observed in this pilot emerged from the total package known as the KMEC initiative. Sustainability of an effective KMEC initiative in other locations will depend to a substantial extent on the maintenance of the levels of support and resources associated with this pilot.

**Major Recommendation**

1. Taking account of the evaluation findings and subject to the recommendations below, the main recommendation is that the *broad framework, processes and material and human resources associated with the KMEC trial be maintained as the basis for a sustainable national roll-out of the KMEC initiative.*

This recommendation is based on the view that the findings of the evaluation indicate that the KMEC initiative can provide positive support for services as they work to assist young children who may be at risk of or experiencing mental health difficulties and to support their families.

This further highlights the overall significance of this developmental period in young children’s lives, and the need to continue the KMEC initiative, which recognises, understands, and intervenes to assist young children who may be at risk of or experiencing mental health difficulties and to support their families.

**Recommendations related to the KMEC Model**

2. *Planning for quality assurance:* A significant feature of the current evaluation involved the development and application of an index to assess the quality of the implementation process. The findings document the influence of quality of implementation on the effectiveness of key elements of this trial of the KMEC initiative. It is recommended that support for high quality implementation, and systematic monitoring of the quality of implementation, be included in all future enactments of the initiative.

3. *Planning for monitoring:* It is recommended that the impact of any future roll-out be carefully monitored to assess its effect in relation to the objectives of the KMEC initiative. Consideration should be given to the design of instruments that can be embedded in a national roll-out that will facilitate this ongoing monitoring of effect.

4. *Supporting Leadership:* Findings based on both implementation quality data and Facilitator reports point to the importance of leadership for the effectiveness of this trial of the KMEC initiative. It is recommended that attention be given to providing explicit support for service leaders in future revision of KMEC content.

5. *Early Childhood education and care professional learning:* KMEC should continue to advocate for pre-service and in-service professional learning opportunities through institutions such as TAFE colleges and universities.

6. *Child risk and protective factors:* It is recommended that the initiative continue to recognise the importance of the protective factors of high quality staff-children relationships and child temperament as core features of the KMEC initiative, and that consideration be given to additional professional learning for staff regarding their importance.
**Recommendations about specific elements of KMEC**

Information generated during the evaluation included a range of specific suggestions for improving the efficacy of KMEC. These are included here for consideration in further development of KMEC processes and content.

7. Maintain the preferred face-to-face, active engagement, professional learning led by expert facilitators.

8. Continue to address the diversity of educators’ learning needs through professional learning curriculum designed to cater for both more and less experienced, and more and less qualified participants who work in a range of contexts.

9. Sustain professional learning opportunities to support, in particular, services that have more difficulties achieving high implementation, but who nevertheless would have the potential to achieve growth given a longer time period of professional learning opportunities.

10. Consider processes for managing professional learning in conjunction with staff turnover such as providing ongoing, facilitated professional learning conducted as ‘start-up’ and ‘refresher’ sessions.

11. Consider additional KMEC professional learning resources and materials to support educators working with children with complex and diverse needs (such children with special learning needs, children in state care).

12. Ensure text and visual materials represent the social and cultural backgrounds of children, families, and educators in services.

13. Continue professional learning with attention to quality of delivery, dosage and fidelity, but with particular attention to the needs of staff around time availability.

14. Encourage and support leadership within early childhood education and care services to continue to build professional learning into the working day of educators where possible.

15. Consider the impact of the differential availability within the sector of funding to support staff attendance at professional learning sessions.

16. Consider how Component 1 can be broadened to extend community networks and links with outside resources and to enable parents to develop a stronger sense of having a ‘voice’ as part of this community.

17. Facilitate the provision of up-to-date information for staff on social-emotional learning, staff-child relationships, temperament and mental health.

18. Consider ways to strengthen the work of services with parents regarding the availability of community resources and the significance of children’s mental health in terms of their overall development.

19. Strengthen Component 4 particularly in terms of helping services to develop policies and referral procedures that will build more effective links with external support agencies.
Acknowledgements

KidsMatter Australian Early Childhood Mental Health Initiative was developed through collaboration between beyondblue, the Australian Psychological Society and Early Childhood Australia, and with funding from the Australian Government Department of Health and Ageing and beyondblue.

beyondblue
This evaluation was commissioned and funded by beyondblue. The Flinders University evaluation team wishes to thank and acknowledge beyondblue for their ongoing support throughout the evaluation. In particular, we would like to acknowledge Brian Graetz and Bella Burns who were highly supportive throughout the evaluation.

Australian Psychological Society and Early Childhood Australia
The commitment and support of the Australian Psychological Society in providing feedback and expertise regarding the development of the evaluation measures was appreciated by the evaluation team. The dedicated support provided by Early Childhood Australia is also acknowledged.

KidsMatter Early Childhood Personnel
The Flinders consortium would also like to extend their gratitude and thanks to the National Project Office, Janelle Gray, and to the KMEC Facilitators, Penny Andersen, Janelle Bowler, Amelia Joyce, Rita Johnston, Maree Kirkwood, Morag Bell, Sandy Clark and Glenda Grummet who, at all times, were dedicated in their support of the evaluation and assistance with data collection.

John P. Keeves AM
The Flinders University KidsMatter Evaluation consortium deeply acknowledges and wishes to thank Professor John Keeves for the substantial time, effort and intellectual rigour that he brought to the statistical analysis of the data collected for this evaluation. His ready availability and willingness to support the team in the analysis has contributed significantly to the outcomes of this evaluation. We also acknowledge the statistical advice of Dr I Gusti Darmawan at the University of Adelaide.

Early Childhood Service Communities
In the course of the two year evaluation the Flinders University evaluation team received sustained cooperation and support from directors, staff, parents and children in the services that participated in the trial. This applied to both the questionnaire data collection and photo stories. We thank all these communities for their efforts, without which the evaluation could not have proceeded.

Aboriginal and Torres Strait Islander peoples
Aboriginal and Torres Strait Islander people should be aware that this document may contain images of people who have since passed away. We acknowledge the objections of some Aboriginal and Torres Strait Islander people and organisations to the term Indigenous. It is used sparingly in this report where appropriate, for example, non-Indigenous people. It is also used where repetition of Aboriginal and Torres Strait Islander would make the text harder to read. This has enabled us to avoid the abbreviation ATSI to apply to people (we do use it to apply to organisations, such as OATSIH). The word Indigenous is capitalised in keeping with current practice, to indicate its specific use to apply to Australian Aboriginal and Torres Strait Islander peoples. It is not capitalised in referring to non-Indigenous systems, institutions and practices.
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