The Royal Australian & New Zealand College of Psychiatrists

Australian Human Rights Commission
Australia's Progress in Implementing the Convention on the Rights of Children

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advocating for equitable access to services

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Royal Australian and New Zealand College of Psychiatrists submission

Consultation on Australia's Progress in Implementing the Convention on the Rights of Children

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to the Australian Human Rights Commission (AHRC) consultation on Australia's progress in implementing the Convention on the Rights of Children. The RANZCP has concerns around the provision of mental health services for children and young persons, the detention of children and families who seek asylum, access to culturally appropriate specialist mental health services for Aboriginal and Torres Strait Islander children and families, especially those living remotely, and other issues around the management of mental health for children and adolescents in Australia.

Around one in seven children and young people have had an experience of mental ill health, and between 21 to 23% of Australia children live in families with a parent who has a mental illness (Maybery et al., 2009). The RANZCP is a strong advocate of the urgent need to improve the prevention, early identification, and treatment of mental illness for young Australians. The RANZCP believes that more needs to be done for Australia to meet its international obligations to children, and ensure positive outcomes for all children facing mental ill health in Australia

To develop this submission, the RANZCP has consulted the Faculty of Child and Adolescent Psychiatry, the Section of Child and Adolescent Forensic Psychiatry, the Aboriginal and Torres Strait Islander Mental Health Committee, Section of Perinatal and Infant Psychiatry, the Family Violence Network and the Asylum Seeker and Refugee Mental Health Working Group.

1. Mental health of children in Australia

Article 24(1) of the Convention on the Rights of Children notes 'the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right to access to such health care services' (United Nations General Assembly, 1989, p7).

The RANZCP considers mental health to be inseparable from a child's overall health and development. In addition, it is clear that children develop and thrive within their families and support and prevention for children entails a family and systemic focus. Effective prevention and intervention requires resourcing and training that recognises and ensures collaboration and service integration across health, mental health, including adult mental health, child development and child protection sectors.

Childhood experiences, developmental trajectories and environments are foundational in the shaping of mental health, health and resilience across the lifespan. There is considerable evidence for the importance and effectiveness of early prevention and intervention with children and families at risk of ongoing adversity and mental health difficulties. Inadequate recognition and treatment of childhood mental health issues can contribute to developmental and relationship problems, loss of education years and employment prospects and serious ongoing vulnerability and self-harm.

According to the Australian Bureau of Statistics, in 2016 suicide was the leading cause of death of children between 5 and 17 years of age. Since 2012 the rate of child deaths by suicide has increased from 2.1 per 100,000 to 2.3 in 2016. While the 2016 rate of child deaths by suicide is lower than the suicide rates for the overall population, the death of any child by suicide is an unacceptable failure of the mental health system in Australia, to identify and effectively support and intervene with vulnerable children (ABS, 2017).

The second Australian Child and Adolescent Survey of Mental Health and Wellbeing, titled *Young Minds Matter,* found that almost one in seven (13.9%) of 4 to 17 year olds in Australia were assessed as having a mental disorder in the 12 months prior to the survey. Of this group, just over one in seven (14.7%) were assessed as having a severe mental disorder. This is equivalent to 1 in 50 (2.1%), or 82,000

Australian children and adolescents overall with a severe mental disorder. Approximately one-fifth of girls aged 16–17 years met clinical criteria for depression based on self-report, while one-quarter of 16–17 year girls reported deliberately self-injuring at some point in their lives. Just over half of children and adolescents with mental disorders accessed information or used services for emotional and behavioural problems. Of those with severe disorders, over 1 in ten young people had not accessed services (Lawrence et al., 2015).

These figures suggest some improvements compared with the first Australian Child and Adolescent Survey of Mental Health and Wellbeing, which found that in 1998 only 1 in 4 young people with mental disorder accessed services (Sawyer et al., 2000). However, there has been a substantial increase of self-harm and other mental health presentations to emergency departments in NSW and in Victoria in adolescents in recent years (Perera et al, 2018; Hiscock et al, 2018), and it seems that rather than increased prevalence of mental health problems, it is more likely that current mental health services are failing to provide alternatives to emergency departments for adolescents in crisis, and that prevention is not being successfully pursued (Sawyer and Patton, 2018). In order to ensure that Australian children enjoy the highest attainable standard of health, the Australian Government must improve the prevention and treatment of mental illness for children and young people around the country.

2. Mental health services for children in Australia

As noted above, the 2013–14 *Young Minds Matter* survey found that there has been a significant increase in service use by children and adolescents with mental disorders in Australia between 1998 and 2013–14. The survey found that service use was higher for children and adolescents with more severe disorders. However, the survey also identified a large number of 4 to 17 year olds with mental disorders that have not had any contact with services (Lawrence et al., 2015). This is of particular concern to the RANZCP, as it is essential that children and adolescents with mental disorders, and particularly the 2.1% with severe disorders, are able to access the expertise of child and adolescent psychiatrists to provide early intervention and ongoing treatment when appropriate.

The Australian Mental Health Commission's 2014 review of mental health services in Australia noted that the Australian Government has been historically responsible for setting direction in the field, although its role has expanded into service provision to target perceived gaps (National Mental Health Commission, 2014). The report noted that children and young people's mental health was an example of such a gap, which the government targets through a number of models and organisations. The review goes on to note that this approach has led to a fragmented system of governance, and that efforts should be made to consolidate services and ensure a targeted approach. In 2015 the Australian Government provided a response to the review, which included several targeted initiatives to improve mental health for children in their early years through to adolescence. As part of this response the government stated it will introduce a single integrated end-to-end school-based mental health program, easy access to telephone and web-based information for children and young people, and a national workforce support initiative (Department of Health, 2015). The RANZCP notes that this commendable approach fails to cover the needs of infants and children under 5, and re-emphasises the importance of the early years for early prevention and intervention.

Critical to the success of the prevention and early intervention of mental illness in childhood is a broadening of the roles and priorities of child and adolescent psychiatrists and general psychiatrists. This could include the provision of leadership to multidisciplinary teams, training of other professionals, advocating for improvements in service delivery, skills in cross-sectoral collaboration and advocacy (e.g. with child protection services) and translating emerging knowledge into practice.

Child and adolescent psychiatrists have the capacity to provide an integrated biological, psychological and socio-cultural approach to children and families with mental illness and its treatment. Unfortunately, the high prevalence of children and adolescents with mental health problems is in direct contrast with a

limited number of child and adolescent psychiatrists (Department of Health, 2016). This issue is compounded by a shortage of child and adolescent psychiatry training posts in Australia. Additionally, the proportion of funding allocated to child and adolescent mental health historically has not matched the proportion of the population experiencing problems (Birleson et al., 2000). A 2018 study found that government expenditure on mental health services for those aged under 24 years comprised around 24% of the amount spent on these services across all ages, however the youngest age group of 0 to 4 year olds were still underserviced relative to need (Segal, Guy, Furber 2018). Segal (2018) found that less than 1% of 0–4 year olds received a mental health service in any one service setting. These disparities mean that child psychiatrists are unable to provide direct care for all those who need it and for the group where early prevention and intervention are likely to be most effective and economical.

The RANZCP notes that in 2017 the Australian Government announced $110 million in additional funding for child and youth mental health. This funding is directed to a number of organisations, including $46 million for beyondblue, $16 million for Emerging Minds and additional funding for the National Support for Child and Youth Mental Health Program. The RANZCP believes that these initiatives need guaranteed long-term funding, and expansion to target particularly at-risk groups of children.

3. Children from vulnerable groups

Under Article 24(1) of the Convention of the Rights of the Child, it is the responsibility of the Australian Government to ensure that every child has the right to the highest attainable standard of health, and that 'no child is deprived of his or her right of access to such health care services' (United Nations General Assembly, 1989, p7). However, the RANZCP notes that several groups of vulnerable children who are at greater risk of mental illness are likely to face barriers in accessing mental health services in Australia. These vulnerable children should be considered for targeted prevention and early intervention programs to prevent and manage emerging and established mental illness.

Groups of vulnerable children include: Aboriginal and Torres Strait Islander children; children living in rural and remote communities; children of parents with mental illness, children with chronic conditions and their siblings; families with low socioeconomic status; children affected by homelessness; children of prisoners; children with culturally and linguistically diverse backgrounds, refugee and asylum seeker children, particularly those detained in on- or offshore locations, or living under temporary visa arrangements; children in out of home care environments; children living in dysfunctional family environments (including domestic violence and abuse); and children who have experienced trauma and abuse (RANZCP, 2010). Children exposed to cumulative adversity are particularly vulnerable.

Aboriginal and Torres Strait Islander children

The RANZCP is concerned that few improvements are being made with regard to the social and emotional wellbeing of Indigenous and Torres Strait Islander children. Over the 5 years from 2012 to 2016, Aboriginal and Torres Strait Islander children and young people accounted for more than a quarter of all suicide deaths in the 5 to 17 age group (ABS, 2017). Barriers to accessing health services, including stigma and remoteness, combined with identified mental illness risk factors for Indigenous children, indicates that greater funding, support and services are needed for this group.

One of the largest studies on child health, the 2005 Western Australian Aboriginal Child Health Survey, found that 24% of Aboriginal children aged 4 to 17 were at high risk of clinically significant emotional or behavioural difficulties (Zubrick et al., 2005). This study also found that, despite the high proportion of Aboriginal children at risk of clinically significant emotional and behavioural difficulties, very few children have had contact with mental health services. Zubrick also found a fivefold increase in the risk of clinically significant emotional and behavioural problems for the children in families dealing with seven or more life stress events. Several years on, the Longitudinal Study of Indigenous Children found that

22.5% of children had scores that put them in the high-risk category for developing clinically significant behavioural problems (FaHCSIA, 2012).

The RANZCP supports programs to improve mental health services for Aboriginal and Torres Strait Island people. For example, the $85 million in funding provided by the Australian Government from 2016 for Primary Health Networks (PHNs) to improve access to culturally sensitive, integrated mental health services is a good step towards integrating culturally safe and appropriate services and decreasing barriers to services for Aboriginal and Torres Strait Islander peoples (Commonwealth of Australia, 2016). More targeted funding for Aboriginal and Torres Strait Islander children, however, would be extremely valuable, particularly in establishing preventative and proactive measures to ensure social and emotional wellbeing from childhood.

Children in youth detention centres

There is a significant body of evidence documenting the links between mental health issues and incarceration, as well as between childhood trauma and future psychosocial problems. Clear evidence has established a relationship between the length of detention and the severity/comorbidity of psychiatric disorders (Bull et al., 2012). Detention has also been found to compound distress in children with prior experience of trauma, torture or neglect (Burrell, 2013). Even short periods of detention have been found to impact children's function (Fazel et al., 2012; Dudley et al., 2012).

It is the RANZCP's position that the incarceration of children should only occur as a last resort, for the shortest possible period of time and with the decision informed by the best interests of the child. Wherever possible, children and young people who have committed offences should be managed in community settings with primary caregivers to ensure their attachment relationships are not threatened. More detail on the RANZCP position on the detention of children in youth detention centres is available in the RANZCP submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory (RANZCP, 2016).

There is currently an urgent need for dedicated specialist adolescent forensic psychiatric services for children in youth detention. Such services are non-existent or inadequate in several Australian jurisdictions. Without adequate levels of developmentally appropriate mental health services, at-risk children and young people in Australian youth detention centres face significant obstacles in their paths to recovery and staff in youth detention centres face significant difficulties in managing children and young people in their care.

Children seeking asylum

As at 31 March 2018, there were less than five children in Immigration Residential Housing, Immigration Transit Accommodation and Alternative Places of Detention (Department of Home Affairs, 2018) on the Australian mainland. Although this represents a substantial reduction in the numbers compared with 2 years ago, the fact that children remain in this situation, and that the policies that enable mandatory indefinite detention to children and their families who seek asylum, is of significant concern to the RANZCP. In addition many children and families, including 22 children, remain in extremely vulnerable circumstances with little or no access to adequate support and intervention in various forms of immigration detention on Nauru (Department of Home Affairs, 2018).

Detention of children is in contravention of responsibilities under the United Nations Convention on the Rights of the Child, specifically it fails to uphold:

- Article 3(1): the best interests of the child must be a primary consideration in all actions concerning children
- Article 37(b): detention must be a measure of last resort and for the shortest appropriate period of time; children must not be deprived of liberty unlawfully or arbitrarily
- Article 37(a),(c): children in detention have the right to be treated with humanity and respect for the inherent dignity of the person
- Article 6(2), 39: children have the right to enjoy, to the maximum extent possible, development and recovery from past trauma
- Article 22(1): asylum-seeking and refugee children are entitled to appropriate protection and assistance (United Nations General Assembly, 1989).

There is now a large body of evidence showing that prolonged detention, particularly in isolated locations, with poor access to health and social services, and uncertainty of asylum seeker claims, is damaging for the health, mental health and development of children and their caregivers. Detention is detrimental to development and mental health and has the potential to cause long-term damage to social and emotional functioning (HREOC, 2004; AHRC, 2014). Unaccompanied minors and families with children are particularly vulnerable. As noted earlier, detention should only ever be used as a last resort, with the child's best interests in mind and for the shortest possible length of time. It is on the basis of this evidence that the RANZCP opposes the mandatory detention of children.

The RANZCP notes that while many children have been moved from offshore detention facilities in the last 5 years, there remains a growing and sometimes neglected cohort of children and young people who are awaiting asylum and immigration claims in community detention, detention facilities in Australia or as family members on temporary protection visas. This status and uncertainty means children and young people are unable to access services and are denied any sense of stability and security. This seriously impacts the mental health of children and young people.

Children in out of home care

Article 20(1) of the Convention on the Rights of the Child notes that 'a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the state' (United Nations General Assembly, 1989, p6). Out-of-home care (OOHC) in Australia is one of a range of services provided to children who are in need of protection and who are unable to live with their birth family. OOHC includes residential care, home-based foster care and placement with relatives or kin.

The number of children aged under 17 years in OOHC continues to increase nationally. At 30 June 2013 there were 40,549 children in OOHC, which then increased to 47,915 children at 30 June 2017 (AIHW, 2014; AIHW, 2018). Of these children, 47% are in relative/kinship care, 38% are in foster care, 7% are in third-party care and 1% are in other types of home-based care. Aboriginal and Torres Strait Islander children are 10 times more likely to be in OOHC than non-Indigenous children (AIHW, 2018). There are complex social and historical reasons for this, including the ongoing impact of the Stolen Generations (Fernandez & Atwool, 2013). It is extremely important that any policies and initiatives in this area adhere to the Aboriginal and Torres Strait Islander Child Placement Principles.

Children and young people in OOHC are a highly vulnerable group with increased physical, mental and social health needs and often limited access to services and support. As a consequence of their exposure and experiences prior to entering care, and within the care system, they are more likely to have significant, often unrecognised and unmet health needs, increased rates of developmental difficulties and are less likely to consistently access health services. The RANZCP is committed to advocating for adequate care and protection, including comprehensive health and developmental

assessment, early intervention, psychosocial treatment and relational support for children in OOHC in order to assist them to achieve their full potential as healthy adults.

Children in OOHC often present with complex psychopathology related to prior experiences with carers, exposure to perinatal risk (e.g. maternal drug use during pregnancy) insecure, disorganised and disrupted attachment relationships, and the cumulative effects of childhood maltreatment including traumatic exposure. These children warrant special attention and priority access to comprehensive health and developmental assessments and multidisciplinary mental health care that can address their complex health, psychosocial and developmental needs within the context of their placement and the care system.

Children in rural and remote areas

In rural Australia there is a well-recognised shortage of mental health professionals. This, along with a number of barriers to accessing health services such as geographical challenges and stigma, leaves children with mental illness at a significant disadvantage.

The *Young Minds Matter* survey found that the 12 month prevalence of mental disorders among 4 to 17 year olds was higher in regional and remote areas than major cities. The prevalence in major cities was 12.9%, while the prevalence in other areas was 14.8% in inner regional, 19% in outer regional and 14% in remote or very remote (Lawrence et al., 2015). An Australian review on the health and development of children in rural and remote Australia found that mental health services for children aged 0 to 12 are particularly difficult to source across all jurisdictions (Arefadib and Moore, 2017). The review noted that services were predominantly located in major township hospitals and required long distance travel for a number of communities. This can disproportionally disadvantage Aboriginal and Torres Strait Islander children and young people affected by mental health problems.

Australian data on suicide by remoteness is largely reflective of the general population and does not provide specifics for rural and remote children. It is worth noting that, for the general population, data collected by the Australian Institute of Health and Welfare indicates that suicide rates for the population tend to increase with remoteness (Harrison & Henley, 2014). While this is not necessarily replicated in child deaths by suicide, it indicates an unacceptable gap in services for rural and remote communities, and children are likely to be unnecessarily disadvantaged because of it. Under the Convention on the Rights of Children, the Australian Government has obligations to improve mental health service delivery for children in rural and remote Australia, in order to ensure these children can reach the highest attainable standard of mental health.

Children exposed to family violence

Children are among the most at risk group affected by family violence, given their unique vulnerability, dependence and sensitivity to the emotional distress and suffering of their caregivers. For some infants and children, the sequelae of family violence will lead to the development of mental illness requiring specialist, evidence-based treatment.

A review paper by Australian Institute of Family Studies (2014) demonstrates that children may experience family violence as direct victims or bystanders or as witnesses. They may even feel impelled to intervene to stop the violence. It is essential that there is specific recognition of the impact of family violence on children and young people in Australia. The RANZCP notes the paucity of Australian research on the impact of family violence on children's mental health, the prevalence of family violence involving children and the optimal service provisions for such children. International literature clearly states the serious negative impacts of family violence on children. As such, the RANZCP recommends greater funding for research to determine the prevalence of harm to children in family violence, its mental

health impacts on children, modes of prevention, the mediating factors, and optimal services required to best meet the needs of such children.

Pregnancy is also noted as a time of increased risk of domestic violence for women. A 2013 report by the World Health Organisation notes greater likelihood of adverse outcomes from domestic violence such as miscarriage, low birth weight, stillbirth. Significant effects on foetal development are noted by the Royal Commission into Family Violence (State of Victoria, 2016). The same report noted far greater risk of harm for Aboriginal and Torres Strait Islander children, and children of refugees. Mental health impacts on children are described as externalising behaviours such as aggression, hyperactivity or internalising behaviours such as depression, anxiety and PTSD, and developmental delays.

4. Recommendations

In order for Australia to improve child health outcomes and meet its obligations under the Convention on the Rights of Children, the RANZCP recommends:

1. Screening for vulnerable families with infants and children aimed at early identification of those at risk or with established mental illness, to enable early referral and appropriate intervention.

2. Expanding the collection of data and research on children's mental health, ensuring that emphasis is placed on the mental health of children and families identified as vulnerable. This will ensure funding is targeted to areas of greatest need and services are appropriately placed.

3. Resourcing and training that recognises and ensures collaboration and service integration across health, mental health, including adult mental health, child development and child protection sectors.

4. Targeted, culturally appropriate and specialised prevention and early intervention programs for young Aboriginal and Torres Strait Islander people and children, particularly those in rural and remote communities.

5. Greater funding for research to determine the prevalence of harm to children from family violence, its mental health impacts on children, modes of prevention, the mediating factors, and optimal services required to best meet the needs of such children.

6. Adequate mental health services for asylum seekers, refugees, and children in Australian detention, including access to health interpreters and access to specialist assessment and treatment, by child and adolescent psychiatrists and other mental health specialists.

7. Additional support for children in OOHC and priority access to comprehensive health and developmental assessments and multidisciplinary mental health care that can address their complex health, psychosocial and developmental needs within the context of their placement and the care system.

8. Increasing the child and adolescent psychiatry workforce to better work with multidisciplinary services and teams to identify and treat children at risk of, and with developing or established, mental disorder.

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