Queensland
Family & Child
Commission

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Submission

February 2022

Contents

Acknowledgement
The Queensland Family and Child Commission (QFCC) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies on which we walk, live and work upon.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to their Elders past, present and emerging.

This submission discusses children's mental health, suicide, suicidality and self harm. It may cause distress for some people. If you need help or support, please contact any of these services:

Lifeline: 13 11 14
Beyond Blue: 1300 22 4636
Kids Helpline (for 5-25 year olds): 1800 55 1800

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Reference: D22/306

Introduction

The Queensland Family and Child Commission (QFCC) is a statutory body of the Queensland Government seeking to give practical effect to the rights of all children and young people in Queensland through awareness, advocacy and accountability.

Under the *Family and Child Commission Act 2014*, the QFCC is responsible for promoting the safety, wellbeing and best interests of children and young people. This includes representing their best interests in decision-making processes.[1]

The QFCC is pleased to have the opportunity to provide feedback to the Mental Health Select Committee's *Inquiry into the opportunities to improve mental health outcomes for Queenslanders* (the inquiry). The QFCC is committed to improving mental health outcomes for children and young people in Queensland. It is important to make sure there are targeted, well-designed, child and youth-focused mental health services available across Queensland.

The QFCC advocates for the voices of children to be heard and their views be taken into consideration in matters affecting them. Children and young people consistently tell the QFCC mental health is one of their biggest concerns and an area in which they wish to see change in the way support services are delivered.

This submission will include comment from young people, including responses from the QFCC's *Voices of Hope: Growing up in Queensland 2020* report and recent consultations with young people that discussed issues related to the terms of reference of the Mental Health Select Committee.

Evidence shows good mental health in childhood is critical to survival and optimal development. Children's mental health is a significant contributor to life-long wellbeing, including economic and social wellbeing. Accordingly, children's mental health requires us to reach beyond the scope of mental health services to include families, education settings and communities.

Australian governments have a responsibility to protect the rights of children in relation to mental health and overall wellbeing under the United Nations Convention on the Rights of the Child (UNCRC). This extends to recognising the potential vulnerability of children as consumers of mental health services.

[1] *Family and Child Commission Act 2014* (Qld), s.4.

Summary of key points

- Good mental health in childhood is critical to optimal development and builds a foundation for life-long wellbeing.
- There is growing evidence of high prevalence of mental health conditions among children and young people, which can continue to cause challenges throughout adulthood.
- Interventions aimed at prevention or early treatment need to be available and accessible to children and young people.
- By providing high-quality mental health support, we could reduce children's contact with policing, youth justice and child protection systems.
- Particular consideration must be given to the intersectionality of mental health needs and involvement with statutory systems such as child protection and youth justice and the correlation of unmet mental health needs and experiences of profound disadvantage such as youth homelessness.
- In circumstances where unmet mental health needs of parents impact upon the safety and wellbeing of children and young people, active efforts should be taken to enable parents to access requisite supports to effectively manage potential risks and promote family preservation.
- Mental health support should be prioritised for children in high-risk cohorts, including children with disability, children in contact with youth justice, children who have experienced domestic and family violence, children living in out-of-home care and children leaving care.
- Services should be available to all children, including children under the age of 12 years.
- Consideration should be given to the ability for children and young people to consent in their own right to mental health services when assessed as Gillick competent.
- Children need to be involved in planning mental health services, to make sure services meet their needs and expectations.
- QFCC Youth Advocates have advised there needs to be stronger mental health support in schools, including mental health education, and a diverse range of youth mental health support services outside clinical settings.
- To enhance the capacity of natural support networks to create communicative and caring environments for children and young people, a targeted awareness and information campaign about identifying and responding to mental health concerns should be considered.
- To meet growing demand, there needs to be more training and stronger incentives for people to study psychology and go into practice, including in regional and rural areas.
- The introduction of culturally grounded assessment tools and culture affirming service models should be prioritised to ensure the mental health needs of Aboriginal and Torres Strait Islander children and young people are addressed, holistically and in the context of intergenerational trauma.
- It is important that children have access to child-friendly complaints processes where mental health services have failed to protect their rights.

The significance of children's mental health

The early years of life are critical to the development of solid foundations for lifelong mental health and wellbeing. Exposure to adverse childhood experiences contributes to poor lifelong outcomes, but supporting children to have a strong start, through strong child and family support services, provides benefits to the whole community.[2]

The extent to which children receive positive experiences in early childhood can influence their life-long mental health. For example, experiences of early childhood which support the development of positive self-esteem, an optimistic outlook on life and good coping skills can prevent the development of mental illnesses later in childhood.

Children's mental health issues are often a response to events that have happened in their lives. Child abuse and neglect are identified as having particularly pervasive and long-lasting effects on children and their futures. The negative repercussions of child abuse and neglect are wide-ranging and impact many aspects of children's lives. These include:

- poor emotional and mental health (e.g. depression, anxiety, eating disorders, suicidal thoughts and attempts, post-traumatic stress disorder)
- lower levels of economic well being
- social difficulties (e.g. insecure attachments with caregivers, which may lead to difficulties in developing trusting relationships with peers and adults later in life)
- cognitive dysfunction (e.g. deficits in attention, abstract reasoning, language development, and problem-solving skills, which ultimately affect academic achievement and school performance)
- high-risk health behaviours (e.g. a higher number of lifetime sexual partners, younger age at first voluntary intercourse, teen pregnancy, alcohol and substance abuse)
- behavioural problems (e.g. aggression, offending behaviours, adult criminality, abusive or violent behaviour).
- poor physical health (e.g. chronic fatigue, altered immune function, hypertension, sexually transmitted diseases, obesity, mental health conditions, lasting impacts or disability from physical injury and increased risk of chronic diseases).[3]

Failure to respond to harm in a timely manner can leave a child physically, socially, emotionally and cognitively impaired, and thereby ill-equipped to experience healthy development into adulthood.

Across the whole population, unresolved childhood trauma of this type erodes national productivity and wellbeing. A study commissioned by Blue Knot and Pegasus Economics determined that the combined budget position of federal, state and territory governments in Australia could be improved by a conservative estimate of $6.8 billion annually by adequately addressing the impacts of child abuse.[4]

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[2] State of Queensland (Queensland Mental Health Commission) 2018, *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan*, accessed 28 January 2022, https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf, p. 26.

[3] Wang, C., and Holton, J. 2007, '*Total Estimated Cost of Child Abuse and Neglect in the United States*, in Prevent Child Abuse America, Economic Impact Study accessed 17 July 2018, http://noexcuseforchildabuseinamerica.com/resources/Economic+Impact+Study+Cost+Of+Child+Abuse.pdf; X Fang, D Brown, C Florence per cent J Mercy, 'The economic burden of child maltreatment in the United States and implications for prevention', *Child Abuse and Neglect*, vol. 36, 2012, p. 156-165; C Kezelman, N Hossack, P Stavropoulos per cent P Burley, *The cost of unresolved childhood trauma and abuse in adults in Australia*, Blue Knot Foundation and Pegasus Economics, Sydney, accessed 17 July 2018 https://www.blueknot.org.au/Portals/2/Economic per cent20Report/The per cent20cost per cent20of per cent20unresolved per cent20trauma_budget per cent20report per cent20fnl.pdf.

[4] Kezelman, C., Hossack, N., Stavropoulos, P., and Burley, P. 2015, *The cost of unresolved childhood trauma and abuse in adults in Australia,* accessed 1 February 2020, *https://www.pc.gov.au/__data/assets/pdf_file/0009/241749/sub047-mental-health-attachment1.pdf*, .

Child abuse and neglect have been found to occur to both males and females in all family types, without regard to cultural context or economic situation. Individual characteristics such as psychiatric status, substance abuse, personality characteristics, attitudes to children, parenting skills, past exposure to physical abuse and/or neglect, as well as situational conditions and family structure have all been investigated and provide possible targets for intervention.[5]

[5] K Saville-Smith 1999, *Familial caregivers' physical abuse and neglect of children: a literature review* accessed 1 February 2022 https://msd.govt.nz/about-msd-and-our-work/publications-resources/literature-reviews/familial-caregiver-s-physical-abuse/index.html, p. 8.

The views of children and young people

It is important to speak to children directly about their mental health. The 2015 *Mental Health of Children and Adolescents* report found rates for depression in 11-17 year olds were significantly higher when young people had self-completed the survey (7.7 per cent), rather than when information was provided by their parent or carer (4.7 per cent).[6]

Under article 12 of the United Nations *Convention on the Rights of the Child*, children have the right to participate in decision-making and have their views heard and considered in the development and implementation of policy. Mental health has been a key area of interest for children and young people consulted by the QFCC since 2014, and one in which children's views are crucially important to develop strong and effective responses.

Rights, Voices, Stories

During 2020, the QFCC recruited 11 'youth researchers' with lived experience of the Queensland child protection system to identify what matters to children and young people involved with the system.[7]

When discussing the importance of health and wellbeing, the youth researchers suggested that mental health services be provided to all children and young people upon entering care, as being removed from their families is a traumatic event.

They also talked about the importance of having access to mental health services during care and when leaving care to support their transition back to their families (if being reunified) or to independent living. These supports should not be limited by arbitrary funding periods, but should be available when young people need them.

Growing up in Queensland

In 2018 and 2020, the QFCC asked children and young people about their emotional and mental health in its *Growing up in Queensland* consultations. Their insights can help us understand the how these children and young people, aged 13-18 years, think about their mental health, and identify the factors that influence their sense of mental wellbeing.

Children and young people continue to tell the QFCC that mental health is something they worry about and something that can prevent them from achieving their goals.[8]

In 2020, one third (33 per cent) of the nearly 6,000 young people who completed the survey self-identified as having an emotional or mental health condition. The high number of participants allow us to see whether experiences of community and optimism differed between groups of teens, according to self-identified mental health status.[9]

Community belonging

Children and young people who reported having an emotional or mental health condition were much less likely than those who did not report having an emotional or mental health condition to feel a sense of community belonging (42 per cent compared with 67 per cent).

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[6] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., and Zubrick, S. 2015, *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing,* Department of Health. accessed 19 January 2022 https://www.health.gov.au/sites/default/files/documents/2020/11/the-mental-health-of-children-and-adolescents_0.pdf

[7] The State of Queensland (Queensland Family and Child Commission) 2020, *Rights, Voices, Stories*, accessed 25 January 2022, https://www.qfcc.qld.gov.au/keeping-kids-more-safe/monitoring-reviewing-systems-protect-children/rights-voices-stories

[8] The State of Queensland (Queensland Family and Child Commission) 2020, *Voices of hope: Growing up in Queensland 2020* and 2018, *This Place I call Home: The views of children and young people on Growing up in Queensland* accessed 11 January 2022 https://www.qfcc.qld.gov.au/keeping-kids-more-safe/listening-children-young-people/growing-queensland

[9] Ibid.

Feeling heard

Children and young people who reported having an emotional or mental health condition were much less likely than those who did not report having an emotional or mental health condition to feel heard by adults (13 per cent compared with nearly 28 per cent).

Feeling safe

Children and young people who reported having an emotional or mental health condition were much less likely than those who did not report having an emotional or mental health condition to feel safe in their communities (47 per cent compared with 70 per cent).

Feeling hopeful

Children and young people who reported having an emotional or mental health condition were much less likely to feel optimistic about the future than those who did not report having an emotional or mental health condition (40 per cent compared with 65 per cent).

Barriers for children accessing mental health support

The 2020 *Growing Up in Queensland* youth survey also asked participants what had stopped them accessing a mental health support service when they needed one. Sixty two percent of respondents said they did not have the confidence to contact a service. Twenty per cent said they didn't think about using a service and 15 per cent said they could not afford to access services. In free text answers, some young people felt their problems were not significant enough to warrant seeking support, while others were afraid of their parents finding out.

Young Minds Can't Wait: QFCC Hackathon 2021

A hackathon is an event where young people come together to 'hack' an issue and come up with youth-led solutions to improve concerns. For *Young Minds Can't Wait*, young people aged 15-25 designed solutions to mental health challenges identified by themselves and their peers through the 2020 Growing up in Queensland survey.

When asked their perspective on mental health, young people made observations under the following themes:

First action if they became Commissioner of the QFCC

- 50 per cent mentioned adding mental health to the curriculum
- 31 per cent mentioned providing mental health training for teachers in schools

Key focus if they became Commissioner of the QFCC

- 46 per cent mentioned focusing on introducing mental health to the school curriculum
- 23 per cent mentioned focusing on increased awareness of mental health
- 30 per cent mentioned focusing on consultation and support about mental health issues

What they think would improve mental health services

- 38 per cent mentioned access to services and funding
- 38 per cent mentioned more promotion of services

Why young people should be involved in decisions about mental health

- 83 per cent mentioned youth being a key stakeholder
- 66 per cent mentioned youth providing unique insight

To meet children's needs and provide for their right to wholistic health care, it is appropriate to explore ways to expand policy and practice in innovative directions. Programs that seek to provide well-balanced experiences and opportunities could include cultural programs, skills building, extended family contact, social and community engagement as well as health and sports programs.

Recent consultations

While preparing this submission, the QFCC asked the Youth Advocates on our Youth Advisory Council about ways to better support mental health in children and young people. Youth Advocates told us there were some useful supports in place to help with their mental health; they rely primarily on friends and family for mental health support, and some have used services that are free and accessible, such as school and university-based counselling services and phone services from headspace and Kids Helpline.

Youth Advocates supported the Commonwealth Government's current policy of providing up to 20 (10 individual and up to 10 group) subsidised allied mental health services sessions under a Mental Health Treatment Plan, but advised many children and young people would not know this option is available to them. There are also barriers to accessing these services – a child or young person would need to have access to a Medicare card and be able to visit a GP for a referral,[10] which may limit access where a child does not want their parents to know they are seeking help.

Youth Advocates also advised there is currently high demand for psychology services and it is common to wait six months or more to book an initial appointment with a psychologist. Some Youth Advocates reported difficulty finding a psychologist they could connect with, or who would provide treatment in a culturally safe manner. The cost of services, which is often only partly covered by Medicare, was also prohibitive to some. Over the long term, increased investment in training and appointing youth-focused psychologists would help to make these services more available, however Youth Advocates also advised there could be benefit in establishing youth support programs in non-clinical spaces to meet emerging needs. Services should be accessible and inclusive for all children, including those who identify as LGBTQIA+. There should be culturally safe services available for Aboriginal and Torres Strait Islander children and young people, and those from a culturally and linguistically diverse background.

While the QFCC acknowledges recent investments in the education sector, youth advocates recommended better mental health support in schools. This could include counselling services, but also mental health education to teach basic techniques such as mindfulness and meditation, as well as provision of information about the signs that they or their friends might be experiencing mental health concerns and how to seek help.

Cost is a significant prohibitive factor for young people seeking mental health support, so services for children and young people should be free to access with accessible referral pathways. These services should be available for all children, including those under 12, who do not currently qualify for many existing services such as those provided by headspace.

Additionally, children and young people need access to youth-friendly and culturally safe complaints mechanisms where mental health services have infringed upon their rights.

[10] Australian Government Department of Health, *Better Access fact sheet – patients* [webpage] accessed 31 January 2022 https://www.health.gov.au/resources/publications/better-access-fact-sheet-patients

Prevalence of mental health conditions among children

In 2015, the *Australian Child and Adolescent Survey of Mental Health and Wellbeing* reported almost one in seven (13.9 per cent) of 4-17 year olds were assessed as having had a mental health condition in the previous 12 months. The most commonly diagnosed conditions were attention deficit hyperactivity disorder (ADHD) (7.4 per cent), anxiety disorders (6.9 per cent), major depressive disorder (2.8 per cent) and conduct disorder (2.1 per cent).[11]

Mental and substance use disorders, particularly anxiety and depression, caused the largest non-fatal burden of disease for children and young people aged 5-19 (43.5 per cent for 5-9 year olds, 42.4 per cent for 10-14 year olds and 47.7 per cent for 15-19 year olds).[12] This suggests interventions aimed at prevention or early treatment need to focus on children, and consider how to support them to enjoy their rights to health care, education and fair treatment in child protection and youth justice matters.

The ongoing oversight and research work of the QFCC can contribute to greater understanding of the interaction between mental health and outcomes for children and young people.

Children and young people in contact with justice services

The 2020 Queensland Government *Youth Justice census summary* suggests almost one third (32 per cent) of young people under supervision had at least one diagnosed or suspected mental health disorder. When considered alongside behavioural disorders (diagnosed or suspected), almost half (46 per cent) of young people under supervision are included.[13]

Recent reviews by the QFCC identifies gaps in the child and family support system for children whose high-risk behaviours are considered too complex to be addressed by universal services, but not complex enough for specialist or statutory services. As a result, they miss out on early, timely responses that may keep them safe and away from involvement in the youth justice system.

The QFCC's 2021 report *Changing the sentence: overseeing Queensland's youth justice reforms* notes these figures are likely to be under-representative as many children and young people involved with justice services are not assessed for cognitive or mental health issues until they are in custody in a detention centre.[14]

Changing the Sentence makes other findings which suggest the mental health needs of children under youth justice supervision are not met, either before coming into contact with youth justice, or while under supervision. It points to findings that difficult life experiences are known to increase the likelihood of a child entering the youth justice system and that more intensive, specialist education and health services, should be available to children in primary school.[15]

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[11] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., and Zubrick, S. 2015, *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing,* p.25, accessed 19 January 2022 https://www.health.gov.au/sites/default/files/documents/2020/11/the-mental-health-of-children-and-adolescents_0.pdf

[12] AIHW 2021, *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018* data table S3.4 accessed 20 January 2022 https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-and-death-in-aus/data

[13] The State of Queensland (Department of Children, Youth Justice and Multicultural Affairs) 2020, *Youth Justice census summary* accessed 18 January 2022 https://www.cyjma.qld.gov.au/resources/dcsyw/youth-justice/resources/yj-census-summary-statewide.pdf Data includes 1,578 young people who were either supervised in the community or in custody in a youth detention centre, in a watchhouse (on remand or sentenced) or in an adult prison on 30 June 2020.

[14] The State of Queensland (Queensland Family and Child Commission) 2021, *Changing the Sentence* accessed 18 January 2022 https://www.qfcc.qld.gov.au/keeping-kids-more-safe/monitoring-reviewing-systems-protect-children/changing-sentence p.54.

[15] Jesuit Social Services and Effective Change Pty Ltd 2013, *Thinking Outside: Alternatives to remand for children* in The State of Queensland (Queensland Family and Child Commission) 2021, *Changing the Sentence* accessed 18 January 2022 https://www.qfcc.qld.gov.au/keeping-kids-more-safe/monitoring-reviewing-systems-protect-children/changing-sentence p.54.

Families in contact with the child protection system

Children in out-of-home care are likely to have faced traumatic situations that can impact their mental health. As a whole, out-of-home care should be provided in a holistic, trauma-informed manner that limits the ongoing impact of trauma on children and young people. Mental health services should be prioritised for children in contact with the child protection system.

Families in contact with child protection are also disproportionately likely to have experienced mental health concerns. In some cases, mental health forms part of the assessment process to determine whether a parent is willing and able to protect and care for their child.

Protective factors such as other adults in the home, social support available to the family, housing and other environmental factors are also considered as part of this assessment.

The QFCC is currently undertaking a review of the Intervention with Parental Agreement (IPA) used by the Department of Children, Youth Justice and Multicultural Affairs to provide support to a child and family where parents are able and willing to work actively to increase safety and reduce risk in the home.

This review is exploring the safety of children subject to an IPA and if they are at the centre of the intervention, with their rights upheld and prioritised. The review is due to be completed in 2022.

Early observations from engagement with stakeholders identify issues such as:

- where children and parents are experiencing mental health concerns, access to appropriate services and waitlists are significantly impacting timeliness of interventions
- mental health concerns can co-exist with factors such as substance abuse and domestic and family violence, consequently requiring a comprehensive, coordinated, and integrated family support plan
- to support children to remain safely at home, mental health support is required across the care continuum from prevention, crisis response, harm reduction, treatment and recovery.

Children who have experienced domestic and family violence

There is growing research showing experience of domestic and family violence can lead to adverse impacts on children's mental health, which can continue throughout adulthood. Child-focused services should take into account the needs of children who have experienced violence, providing trauma-informed and culturally responsive support in environments where children feel physically and emotionally safe.[16]

The need for consent

There should be some consideration of the requirements for parents to consent to children receiving mental health services. There is some concern that, for some children, parents may not have the skills or willingness to provide positive behavioural or mental health guidance. There will also be children whose parents will refuse, disengage or evade supports, the reasons for which can be numerous. Both these groups should be identified with those needing intensive outreach supports and additional actions considered for inclusion, to make sure each child's right to mental health care and support is upheld.

For young people in Australia under the age of 18 years, the ability to provide consent (in a broad range of contexts) rests with a parent or legal guardian. Exceptions to this principle apply, particularly in relation to the ability of a young person to consent to medical treatment.

A landmark case in the UK in 1986 (the *Gillick* case) established that a doctor is entitled to provide medical treatment to a child without parental consent where the child has *a sufficient understanding and intelligence to*

[16] Campo, M. 2015, *Children's exposure to domestic and family violence: key issues and responses*, Australian Institute of Family Studies, accessed 2 February 2022, https://aifs.gov.au/cfca/publications/childrens-exposure-domestic-and-family-violence.

enable him or her to understand fully what is proposed.[17] It promoted the position that parents' power to consent to (or refuse) medical treatment for a child *diminishes gradually as the child's capacities and maturity grow and that this rate of development depends on the individual child*.[18]

This notion was further upheld by the United Nations Convention on the Rights of the Child in 1990:

> in accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests.[19]

The concept of Gillick competency (as it became known) was used as precedent by the High Court of Australia in a related matter in 1992, cementing it within Australia's common law.[20]

In line with this, children can consent for medical or mental health care if the treating healthcare professional determines they have capacity to do so in the absence of parental guidance.[21] A parent is only able to consent to or refuse medical or mental health treatment on behalf of a young person if they are not mature enough to make this decision themselves.[22,23]

However, information suggests the ability for young people to consent in their own right to services and access these may not be understood.

Mental health—and access to mental health services—have been identified as a serious issue by young people in Queensland. The QFCC's *Growing Up in Queensland* initiative surveyed young people around the state during 2020.[24] Less than half of the young people surveyed were aware of the support services available to them and 62 per cent stated they lacked the confidence to contact these services.

Other barriers to accessing mental health services identified by young people included affordability, limited transport and 'not being allowed'. Stigma within families around mental health was cited as a barrier as well as fear of parents finding out their child had accessed services without their consent.

> Several of my friends have signs of depression and anxiety and have tried to ask for help from their parents to take them to a psychologist but they refuse to and say it is not real and it's just a phase. Even if it is a phase WE NEED HELP at this point in time so listen to us and please help! - Female, 17 years, South East Queensland

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[17] Lennings, N. 2015, Forward, Gillick: *Are competent children autonomous medical decision makers? New developments in Australia* in Journal of Law and the Biosciences, Volume 2, Issue 2, July 2015, accessed January 31 2022 https://doi.org/10.1093/jlb/lsv028 pp. 459–468.

[18] High Court of Australia 1992, *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case) HCA 15 1992, 175 CLR 218*

[19] Committee on the Rights of the Child 2013, *Convention on the Rights of the Child: General comment no. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health*, https://digitallibrary.un.org/record/778524, Art.24

[20] High Court of Australia 1992, *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case) HCA 15 1992, 175 CLR 218*

[21] ReachOut, *What is age and confidentiality?* [webpage] accessed 31 January 2022 https://au.reachout.com/articles/what-is-age-and-confidentiality

[22] Caxton Legal Centre 2016, Medical treatment of children. *The Queensland Law Handbook* accessed 31 January 2022 https://queenslandlawhandbook.org.au/the-queensland-law-handbook/family-law/parents-children-and-the-law/medical-treatment-of-children/

[23] MH Law Queensland, *Young people and medical consent* [webpage] accessed January 31 2022 https://mhlawqld.com.au/top-legal-issues/carers/carers-young-people-and-medical-consent/

[24] Queensland Family and Child Commission, 'Mental health findings', *Growing Up in Queensland 2020* (unpublished). Information provided by the Queensland Family and Child Commission 30 March 2021.

> I tried talking to my parents about my declining mental health and they blew it off and came up with excuses so I don't talk to them about it anymore. - Female, 14 years, South East Queensland

> There are times when we need support on decision making in tough circumstances where we can't talk to our parents—we need to know how to access services without their knowledge and permission. - Female, 18 years, Far North Queensland

Worryingly, 39 per cent said that when they have needed support in the past, they have not sought help from any member of their support network and have kept their problems to themselves. A theme in young people's responses was feeling that their problems aren't 'big enough' to warrant seeking help and not wanting to divert resources from people who need it more.

> I don't know if my problems are serious enough to talk to someone, I know people that are dying and I'm here complaining about anxiety. - Female 14 years, Central Queensland

Young people suggested apps and online counselling services, free services for young people and being able to access these services anonymously, discretely and without parents' knowledge would be beneficial.

Intergenerational trauma

Colonisation and subsequent government policies and practices have disrupted Aboriginal and Torres Strait Islander peoples' connection to culture and cultural identity. Despite their strong and rich cultural and community networks, with ways of raising children that encourage their development, resourcefulness and resilience,[25] Aboriginal and Torres Strait Islander families face ongoing historical and community trauma that have lasting consequences passed from generation to generation.[26]

While most Aboriginal and Torres Strait Islander children live safely at home and have developed a clear identity linked to their communities and culture,[27] family trauma and loss of parenting skills[28] contribute to the over-representation of Aboriginal and Torres Strait Islander children in child protection systems. Aboriginal and Torres Strait Islander children aged 0-17 continue to be more likely to be the subject of child protection notifications, investigations and substantiations, and on care and protection orders than their non-Indigenous peers.[29]

Parental mental health issues are a commonly identified risk factor in state child protection intervention. Early help seeking behaviour is often compromised due to concerns that seeking support can result in unwelcome or unnecessary surveillance and intrusion into many aspects of a family's life. Access to particular types of support can be contingent upon involvement with and subsequent referral by statutory systems. This type of conditional access operates as a significant disincentive to proactive help seeking behaviour.

Further, the current lack of dedicated, culturally safe services across the continuum of support creates a significant challenge to ensuring that Aboriginal and Torres Strait Islander people have access to the right type of support, when and where it is required. In this context, there needs to be a clear focus on ensuring equitable access to trauma-informed, culturally safe mental health services for Aboriginal and Torres Strait Islander

[25] The State of Queensland (Department of Communities, Child Safety and Disability Services) 2017, *Our Way*: *A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037,* accessed 31 January 2022 https://www.cyjma.qld.gov.au/resources/campaign/supporting-families/our-way.pdf p. 4.
[26] Aboriginal and Torres Strait Healing Foundation 2014, *Prospective cost benefit analysis of healing centres*, accessed 31 January 2022 https://healingfoundation.org.au/app/uploads/2017/01/CBA-final-SINGLES-for-screen.pdf p. 4.
[27] The State of Queensland (Department of Communities, Child Safety and Disability Services) 2017, *Our Way*: *A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037,* accessed 31 January 2022 https://www.cyjma.qld.gov.au/resources/campaign/supporting-families/our-way.pdf p. 4.
[28] Aboriginal and Torres Strait Healing Foundation 2014, *Prospective cost benefit analysis of healing centres,* accessed 31 January 2022 https://healingfoundation.org.au/app/uploads/2017/01/CBA-final-SINGLES-for-screen.pdf p. 5.
[29] Productivity Commission, *Report on Government Services,* 2021, Table 16A.1.

children, young people and families. These services must be designed and delivered in partnership with communities to meet the needs of the children and families they support.

There is also a need for culturally appropriate mental health assessment tools to be used by professionals. Research commissioned by the National Suicide Prevention Taskforce (released in 2020) in relation to children in out-of-home care has called for:

- culturally appropriate interventions for Aboriginal and Torres Strait Islander children and young people that better recognise individual, social, organisational and community aspects of health and healing
- culturally specific suicide risk assessment (such as the Westerman Aboriginal Symptom Checklist for Youth (WASC-Y), which is the first culturally and scientifically validated psychological test developed specifically for Aboriginal Australian youth aged 13-17 years
- trauma-informed care models for out-of-home care placements
- specific trauma interventions for children who have experienced complex trauma
- holistic interventions that target correlates of suicidal behaviour and poor outcomes, such as alcohol and substance use and mental health issues.[30]

These findings highlight the importance of secondary services to support family functioning and positive parent–child relationships. Investment in services to identify and treat early signs of psychological distress in children, using culturally appropriate assessment tools, is also critical.

Children with disability

Children and young people with pre-existing disability have been shown to have poorer mental health than other young people. This lower subjective wellbeing is shown to not be inherently associated with disability but contingent on experiences of social exclusion and financial hardship.[31]

People with disability are more likely than people without disability to experience low social support, financial hardship and higher rates of mental health concerns. Evidence suggests environmental impacts such as low social support and financial hardship can contribute to mental health outcomes. Policy that focuses on improving these factors and does not further disadvantage the individual can help to improve the overall wellbeing of people with disability.

Mental health professionals should be trained to provide appropriate support to children of all levels of ability.

Government strategies and service delivery approaches that promote a more inclusive society are also important, as is providing adequate physically and financially accessible mental health services. Without this, we risk neglecting the mental health needs of children and young people with disability.

In addition, there is a need to provide targeted, specialist responses to children with Fetal Alcohol Spectrum Disorder (FASD). FASD is recognised as a congenital condition under the National Disability Insurance Scheme,[32] and is known to be a factor in children's involvement with the youth justice system. In a 2017 Telethon Kids

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[30] Trew, S., Russell, D., Higgins, D. and Stewart, J. 2020, *Effective Interventions to Reduce Suicidal Thoughts and Behaviours Among Children in Contact with Child Protection and Out-of-Home Care Systems: A rapid evidence review,* Australian Catholic University 2020 accessed 31 January 2022 https://www.acu.edu.au/-/media/feature/pagecontent/richtext/about-acu/institutes-academies-and-centres/icps/_docs/suicide-prevention-rapid-evidence-review-by-icps-20200914-1-2020.pdf

[31] Emerson, E., and Hatton, C. 2007, *Mental health of children and adolescents with intellectual disabilities in Britain*, Br J Psychiatry 191:493–499 p.494 accessed 20 January 2022 https://doi.org/10.1192/bjp.bp.107.038729

[32] Commonwealth of Australia (National Disability Insurance Scheme), *List B – Permanent conditions for which functional capacity are variable and further assessment of functional capacity is generally required*, accessed 7 February 2022, https://www.ndis.gov.au/about-us/operational-guidelines/access-ndis-operational-guideline/list-b-permanent-conditions-which-functional-capacity-are-variable-and-further-assessment-functional-capacity-generally-required.

Institute study, 30 to 40 per cent of young people held in Western Australia's Banksia Hill Detention Centre were found to have FASD, 'characterised, by severe, pervasive neurodevelopmental impairment' which can contribute to a young person's offending behaviours.[33]

In March 2021, the Senate Community Affairs References Committee released its report *Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder*. This report states the prevalence of FASD in Australia is 'largely unknown and believed to be significantly underreported' but could affect five per cent of the Australian population, including between two and nine percent of babies born each year.[34] It shows diagnosis of FASD is limited in Australia and access to support through the NDIS can be difficult. [35]

The report states programs should be in place to help children with FASD develop social and emotional skills, to reduce the risks of mental health issues, offending behaviour and substance misuse later in life.[36] In addition, the report recognises the importance of Aboriginal and Torres Strait Islander community-led approaches, which should be provided with adequate and long-term investment.[37] It would be important to consider how to meet the demand for these programs in Queensland, to address the causes and symptoms of mental health conditions in young people with FASD, who are at greater risk of contact with the youth justice system.

Children in regional and remote areas and national workforce shortages

Despite overall prevalence of mental illness being broadly similar across rural and urban Australia,[38] those living outside major cities have less access to in-person mental health care due to uneven distribution of psychiatrists, mental health nurses and psychologists. National mental health workforce data indicates the further away from a major city you live, the fewer mental health specialists work in your area: in 2019 almost 9 out of 10 psychiatrists (87.1 per cent) worked in major cities, compared with 72.2 per cent of the Australian population who lived in major cities. In major cities, there were 16.5 FTE psychiatrists per 100,000 population, 6.9 in inner regional, 5.5 in outer regional, 6.7 in remote areas and 2.6 in very remote areas. [39]

More than 8 in 10 psychologists (82.2 per cent) worked in major cities in the same year. In major cities there were 109.6 FTE psychologists per 100,000 population, 64.6 in inner regional, 47.4 in outer regional, 42.2 in remote and 31.1 in very remote areas. In 2019, major cities also had the highest rate of mental health nurses (96.1 FTE per 100,000), followed by inner regional (85.7), outer regional (56.8), remote (56.2) and very remote (34.8) areas.[40]

Demand for mental health treatment has long outstripped the available supply in Australia. Capacity and capability shortages have sparked concerns about limited access to treatment and premature discharge to

[33] Bower, C. et al 2018, 'Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia', *BMJ Open*, doi:10.1136/ bmjopen-2017-019605, p. 1.
[34] Commonwealth of Australia (The Senate) 2021, *Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder*, accessed 7 February 2022, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/FetalAlcoholSpectrumDi/Report, p. 23.
[35] Ibid., p. xiv.
[36] Ibid., p. 88.
[37] Ibid., pp. 122-131.
[38] National Rural Health Alliance 2017, *Mental health in rural and remote Australia* fact sheet accessed 27 January 2022 http://ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf
[39] AIHW 2021, *Mental health services in Australia—Mental health workforce 2019* data set accessed 27 January 2022 https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce
[40] AIHW 2021, *Mental health services in Australia—Mental health workforce 2019* data set accessed 27 January 2022 https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce

manage pressure for mental health beds,[41] exacerbating challenges caused by a lack of safe accommodation options and step-down services available for vulnerable children and young people.

The National Mental Health Workforce Strategy Taskforce is considering the quality, supply, distribution, and structure of Australia's mental health workforce. The background paper notes the critical shortage of mental health services with particular shortfalls in subspecialties such as child and adolescent psychiatry.[42]

Suicide among children

The QFCC is responsible for a number of functions relating to child deaths in Queensland. This includes maintaining the Child Death Register, researching the risk factors associated with child deaths, and making recommendations to prevent future deaths.

The Queensland Child Death Register is a detailed database about the lives and deaths of children who have died in Queensland since 2004. While the death of any child is devastating, the death of a child due to suicide warrants consideration of the circumstances leading to such deaths, to examine whether prior attention to the needs of the child could have prevented their death.

Findings of *Counting lives, changing patterns: Findings from the Queensland Child Death Register, 2004–2019* indicate an increasing trend in child suicides in Queensland over time: the annual rate of suicide increased from 1.7 per 100,000 in 2004–2008 to 2.1 per 100,000 in 2015–2019, an average increase of 2.6 per cent per year.[43]

Data from the Queensland Child Death Register shows over the last five years, 132 children aged 0-17 died from suicide (an average of 26 deaths per year, at a rate of 2.3 deaths per 100,000). Over this period, suicide was the leading cause of death for 15–17 year olds and the leading external cause of death for 10–14 year olds.

Sadly, in the financial year 2020-21, there were 30 confirmed or probable suicide deaths of children, an increase from 20 in the year prior.

Gender

During the past five years, the average suicide rate for males was 1.3 times the rate for females (5.8 deaths per 100,000 males aged 10–17 years, compared to 4.5 deaths per 100,000 females aged 10–17 years). Of the 30 recorded suicide deaths of children in 2020-21, eighteen were male (70 per cent) and twelve (30 per cent) were female.

Age

During the past five years, the suicide rate for children aged 15–17 years was five times the rate for children aged 10–14 years (10.6 deaths per 100,000 aged 15–17 years, compared to 2.0 deaths per 100,000 children aged 10–14 years). In 2020-21, 24 recorded suicide deaths of children (80 per cent) were aged 15–17 years and six (20 per cent) were 10–14 years old.

Indigenous status

Aboriginal and Torres Strait Islander children are consistently over-represented in suicide statistics. Aboriginal and Torres Strait Islander children make up approximately eight per cent of the child population in Queensland,

[41] Watts, J. 2019, *Mental health services in crisis are abandoning patients to meet targets* The Guardian 14 May 2021, accessed 31 January 2022 https://www.theguardian.com/commentisfree/2019/may/14/mental-health-services-crisis-patients-vulnerable-off-rolled; Senate Select Committee on Mental Health 2006, *A National Approach to Mental Health: From crisis to community* accessed 31 January 2022 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/index

[42] ACIL Allen 2021, *National Mental Health Workforce Strategy - Background Paper* p.17 accessed 31 January 2022 https://acilallen.com.au/uploads/media/NMHWS-BackgroundPaper-040821-1628485846.pdf

[43] The State of Queensland (Queensland Family and Child Commission) 2020, *Counting lives, changing patterns: Findings from the Queensland Child Death Register, 2004–2019* p.20 accessed 17 January 2022 https://www.qfcc.qld.gov.au/sites/default/files/2021-05/QFCC per cent2016 per cent20Year per cent20Review per cent20-Web per cent20Version.pdf

however long-terms trends indicate they accounted for more than 25 per cent of child suicides (recorded between 2004 and 2019).[44]

In the five financial years from 2016–17 to 2020–21 Aboriginal and Torres Strait Islander children were more than three times as likely to die from suicide than their non-Indigenous counterparts (6.1 per 100,000 compared with 1.9 per 100,000). In 2020-21, seven child suicides were Aboriginal and/or Torres Strait Islander children (23.3 per cent).

Contact with child safety

Four children who died by suicide in 2020–2021 were known to Child Safety in the 12 months prior to their deaths (13.3 per cent). This is a decrease from eight of 20 suicide deaths (40 per cent) the year before. During the past five years, children known to Child Safety have been more than 3 times as likely to die from suicide.

Recognising the high rates of suicide among children known to Child Safety in Queensland, the Child Death Review Board undertook a review to consider the circumstances of the suicide deaths of eight children known to Child Safety.

Suicide prevention study

The Child Death Review Board (CDRB) was established by the *Child Death Review Legislation Amendment Act 2020* and commenced on 1 July 2020. Hosted by the QFCC, the CDRB considers all deaths of children known to Child Safety in Queensland.

In 2020, the CDRB commissioned Brett McDermott, Professor of Psychiatry at James Cook University, to review eight recent suicides of children known to child safety. The report, entitled *Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*, provides insight into the significant impact of adverse childhood experiences (ACEs) on children's mental health and risk of suicide.[45] It offers a series of suggested priority areas to reduce present and future risk of suicide in highly vulnerable infants, children and young people.[46]

Of particular relevance to the Mental Health Select Committee are the following priority areas:

- **Shared understanding of the acute and long-term effects of adverse childhood experiences across all services that have dealings with children and families**
  Organisations that deal primarily with children (for example education, child protection, paediatrics, child and youth mental health and juvenile justice) have different understandings of the effect of ACEs on children. These sectors could benefit from a shared framework that summarises this information and includes recent significant developments.

  A shared education program with tiers based on the degree of clinical knowledge required would help disseminate the new shared framework.

- **Engage in a State and National conversation about new investment to expand services for infants and pre-school children and their carers**
  Although there has been significant investment in youth mental health services over the last 20 years, no similar investment has occurred for children with mental health presentations. Even less funding is provided to

[44] The State of Queensland (Queensland Family and Child Commission) 2020, *Counting lives, changing patterns: Findings from the Queensland Child Death Register, 2004–2019* p.20 accessed 17 January 2020 https://www.qfcc.qld.gov.au/sites/default/files/2021-05/QFCC per cent2016 per cent20Year per cent20Review per cent20-Web per cent20Version.pdf
[45] McDermott, B. 2021, *Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide,* Queensland Child Death Review Board, accessed 17 January 2021 https://www.cdrb.qld.gov.au/wp-content/uploads/2021/10/CDRB-PREVENTING-SUICIDE-REPORT-by-Professor-Brett-McDermott-FINAL-1.pdf.
[46] Ibid, pp. 65-69

the service system around intervening with parents and infants and parents and preschool children. This is despite robust evidence (including much of the biological evidence detailed in McDermott's report) that investment in the early years could do much to mitigate damage inherent to ACEs at critical times of brain development.

Such a service system could include assessment of infants and pre-school children who are in the child protection system, who either:

- demonstrate mental health challenges (such as anxious avoidant attachment or reactive attachment disorder or significantly dysregulated behaviour involving eating, sleep or emotional or behavioural control), or
- have experienced high numbers of ACEs (5+) and who would benefit from an intervention regardless of whether they demonstrate mental health challenges.

- **Collaborate with Aboriginal and Torres Strait parents, relatives, children and other stakeholders to create new service models that engage Aboriginal and Torres Strait Islander young people and their families.** Service providers should be collaborating with Indigenous elders, parents, and community members to create innovate models of care which lead to engagement of Aboriginal and Torres Strait Islander young people. Such a program could be based in strong links to country and Indigenous identity, instead of being clinical or based in a western tradition of language-based therapies.

- **Consider Multisystemic therapy [or other specialised therapy] for young people who currently do not have their needs met by existing services.**
  Some young people with very high ACE scores are difficult to support through traditional schooling as they exhibit oppositional, defiant, violent, and truant behaviours and often start alcohol and drug use at an early age. These young people often do not do well in the clinical setting and are unable to tolerate language-based strategies. An additional specialised therapy service, beyond that offered through child and adolescent mental health services and Evolve Therapeutic Services is needed for these young people. Multisystemic Therapy (MST), which was designed for such hard-to-engage young people is being used in New Zealand and Western Australia, providing Queensland with an opportunity to assess the effectiveness of this therapy for young people for whom existing services are not suitable.

A full list of McDermott's suggested priority areas to reduce present and future risk of suicide in highly vulnerable infants, children and young people are available in the report on pages 65-69.

Suicidality and self-harm among children

Suicidal behaviour and incidents of self-harm among children indicates the mental health issues are broad and serious. The soon to be published 2020-21 Queensland child death report shows that, in 2020-21, approximately 8500 ambulance callouts occurred for suicidal behaviour and self-harm-related incidents involving children (including both fatal and non-fatal injuries).[47]

This indicates that for every youth suicide there were around 280 callouts to treat children's suicidal behaviour or self-harm incidents. The majority (58.5 per cent) of call outs to treat children in suicidal behaviour or self-harm incidents were for children aged 15-17 years (4,938). Thirty-nine per cent (3,329) were for children aged 10-14 years while a smaller portion (174) were for children aged 5-9 years. Female patients accounted for 64 per cent of these of callouts.

[47] The State of Queensland (Queensland Family and Child Commission), *2020-21 Annual Report: Deaths of children and young people Queensland* (pending publication)

The rights of children and young people

The QFCC continues to have an interest in the impacts of mental health on the rights of children and young people, including their rights to be provided with health care, disability support and education, and to participate in decisions made about their lives. We will continue to raise awareness, advocate and seek accountability from government to make sure children can access the mental health support they need to live full and meaningful lives. We appreciate the opportunity to take part in this process and would be happy to provide more information.