



Australian
Human Rights
Commission

Inquiry into the Social and Economic Benefits of Improving Mental Health

Submission to the Productivity Commission

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1 Introduction

1. The Australian Human Rights Commission (AHRC) welcomes the opportunity to make this submission to the Productivity Commission's *Inquiry into the Social and Economic Benefits of Improving Mental Health* (the Inquiry). The AHRC also welcomes the Inquiry's broad scope in examining how workplaces, education, justice systems, housing and social services can support mental health and social and economic participation.

1.1 About the Australian Human Rights Commission

2. The AHRC is a national human rights institution, with recognised independent status and roles in United Nations human rights fora. The AHRC undertakes a range of policy development and research tasks, which aim to promote compliance with Australia's human rights obligations, while also investigating and conciliating complaints of unlawful discrimination and breaches of human rights.
3. The AHRC is established by the Australian Human Rights Commission Act 1986 (Cth). A key function of the AHRC is to provide advice and submissions to parliaments and governments to develop laws, policies and programs.¹

2 Summary of recommendations

2.1 Recommendations to improve the mental health of people with disability

4. **Recommendation 1:** that all Australian governments examine and reform mental health laws, frameworks and policies to ensure alignment with the *Convention on the Rights of Persons with Disabilities* (CRPD). This includes implementing recommendations from the UN Committee on the Rights of Persons with Disabilities (CRPD Committee) to:
 - review all legislation that authorises involuntary hospitalisation or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders
 - review all legislation that authorises medical intervention without the free and informed consent of the persons with disabilities

- eliminate the use of restrictive practices, such as chemical, mechanical and physical restraints and seclusions
 - replace substituted decision-making regimes with decision-making support regimes, in line with the National Decision-Making Principles proposed by the Australian Law Reform Commission in the *Equality Capacity and Disability in Commonwealth Laws* report, and
 - ensure that people with psychosocial disability and mental health conditions have the procedural guarantees as others in the context of criminal proceedings.
5. **Recommendation 2:** that the Productivity Commission consider the CRPD Committee's concluding observations on Australia's second and third reports, which are expected to be released in October 2019.

- ## **2.2 Recommendations to improve the mental health of children and young people**
6. **Recommendation 3:** that the Australian Government establish a national research agenda for children and young people engaging in non-suicidal self-harm and suicidal behaviour.² This research agenda should prioritise:
- the standardisation of terms and definitions to describe the range of thoughts, communications, and behaviours that are related to intentional self-harm, with or without the intent to die
 - understanding the multiplicity of risk factors central to effectively targeting and supporting children and young people
 - understanding the impact of different protective factors, how they are interrelated, whether some are more predominant than others, or whether specific combinations offer more protection
 - the direct participation of children and young people in research about intentional self-harm, with or without suicidal intent
 - understanding the psychological mechanisms underlying suicide clusters
 - understanding incidence and mechanisms leading to clustering of intentional self-harm without suicidal intent

- evaluating the effectiveness of postvention services
 - evaluating the effectiveness of gatekeeping training programs on actual outcomes for children and young people
 - increasing the awareness of primary caregivers about risk factors and warning signs
 - investigating ways to restrict access to the means used for intentional self-poisoning in children and young people
 - finding effective ways to encourage children and young people to access appropriate help or support for early signs and symptoms of difficulties
7. **Recommendation 4:** that the Australian Government strengthen and develop surveillance of intentional self-harm, with or without suicidal intent, through:
- The Australian Government funding an annual report on deaths due to intentional self-harm involving children and young people aged 0-17 years using the agreement reached between the Australian Bureau of Statistics; the Registrars of Births, Deaths and Marriages; and state and territory Coroners on the dissemination of unit record data.
 - The Australian Institute of Health and Welfare including a section using disaggregated data about hospitalisations for intentional self-harm involving children and young people aged 0-17 years in its regular series on hospitalisations for injury and poisoning in Australia.
 - The Australian and New Zealand Child Death Review and Prevention Group continuing its work in relation to the development of a national child death database, in conjunction with the Australian Institute of Health and Welfare, and providing an annual progress report.
8. **Recommendation 5:** that the Australian Government collect national data on children and young people who die due to intentional self-harm through:
- The use of the standardised National Police Form, in all jurisdictions. This should include an electronic transfer to the National Coronial Information System. A plan to monitor the outcomes of all jurisdictions using the standardised National Police Form should be

developed, and the possibility of incorporating a range of demographic, psychosocial and psychiatric information specific to children and young people should be investigated.

9. **Recommendation 6:** that the Australian Government develop a national plan for child wellbeing, using the CRC as its foundation.
10. **Recommendation 7:** that the Australian Government increases prevention measures and responses to family violence that address the distinct impacts on children.
11. **Recommendation 8:** that the Australian Government expands and funds the delivery of child targeted mental health and other necessary support services.
12. **Recommendation 9:** that the Australian Government provides appropriate and specific physical and psychological rehabilitation for all children arriving in or returning to Australia who may have been involved in armed conflict.
13. **Recommendation 10:** that the Australian Government develop a national children's data framework to ensure appropriate data collection that supports policy making on child rights issues.

2.3 Recommendations to improve the mental health of Aboriginal and Torres Strait Islander peoples

14. **Recommendation 11:** that Australian governments invest in the identification and provision of culturally appropriate services to Indigenous children and young people in crisis situations.
15. **Recommendation 12:** that Australian governments work in partnership with Indigenous peoples and organisations to build upon the findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) to empower communities to lead their own solutions.
16. **Recommendation 13:** that Australian governments build upon the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy by working in partnership with Indigenous peoples and organisations to develop a renewed Strategy and fully-funded Implementation Plan with a focus on preventing child and youth suicide.³
17. **Recommendation 14:** that the Council of Australian Governments work with the Coalition of Peaks to develop social and emotional wellbeing and

suicide prevention targets and indicators within the refreshed Closing the Gap Strategy.

3 A human rights approach to mental health

18. The AHRC recommends that the Productivity Commission take a human rights approach to strengthen its Inquiry. A human rights approach is essential to enable people with mental health conditions to participate socially and economically on an equal basis with others.
19. A human rights approach to mental health requires the recognition of the right of everyone to the enjoyment of the highest attainable of physical and mental health, without discrimination. It also involves ensuring that efforts to realise this right do not violate a person's other human rights or fundamental freedoms.

3.1 Integrating a human rights perspective into mental health policies and services

20. In 2017, the United Nations Human Rights Council expressed concerns that people with mental health conditions are subject to widespread discrimination, stigma, prejudice, violence, social exclusion and segregation, unlawful or arbitrary institutionalisation, over medicalisation and treatment practices that fail to respect their autonomy, will and preferences.⁴ The Council reaffirmed the obligations of States to promote and protect human rights and fundamental freedoms and to ensure policies and services related to mental health comply with international human rights norms.
21. The Council called upon and urged States to take a number of actions to 'fully integrate a human rights perspective into mental health and community services ... and to promote the right of persons with mental health conditions or psychosocial disabilities to full inclusion and effective participation in society, on an equal basis with others'.⁵ This included abandoning 'all practices that fail to respect the rights, will and preferences of all persons, on an equal basis' with others⁶ and supporting 'persons with mental health conditions or psychosocial disabilities to empower themselves in order to know and demand their rights'.⁷
22. In particular, the Human Rights Council acknowledged that the CRPD laid the foundation for a paradigm shift in mental health for a model based on respect for human rights.⁸

23. The AHRC recommends that the Productivity Commission consider the rights and particular situations of people with disability, children and young people and Aboriginal and Torres Strait Islander peoples in its Inquiry. The international human rights frameworks and key issues for these groups are outlined in the following sections.

4 People with disability

4.1 **The Convention on the Rights of Persons with Disabilities**

24. Australia ratified the CRPD in July 2008. The CRPD requires Australia to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all people with disability, and to promote respect for their inherent dignity.
25. Article 1 of the CRPD states that ‘persons with disabilities’ include ‘those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’. This includes people with psychosocial disabilities or mental health conditions.
26. The CRPD embraces a social or human rights model of disability and moves away from a medical model of disability. The CRPD provides a range of rights, tailoring and applying traditional human rights to the specific human rights concerns of people with disability. The AHRC recommends that the following rights should be incorporated into the Productivity Commission’s framework of inquiry:
 - a. **The highest attainable standard of health** (Article 25): this includes without discrimination on the basis of disability. This means they have the right to make decisions affecting their own health and bodily integrity, the right to free and informed consent (including the right to refuse treatment) and the right to be free from non-consensual medical treatment.
 - b. **Equal recognition before the law** (Article 12): this includes a right to enjoy legal capacity on an equal basis with others and to have access to support they may require in exercising their legal capacity.
 - c. **Liberty and security of the person** (Article 14): this includes a right not to be unlawfully or arbitrary deprived of their liberty. Any

deprivation of liberty must be in conformity with the law and the existence of a disability shall in no case justify a deprivation of liberty.

- d. **Freedom from torture and cruel, inhuman or degrading treatment or punishment** (Article 15): the CRPD Committee has stated that the following may amount to cruel, inhuman or degrading treatment or punishment: the use of chemical, physical or mechanical restraints; prolonged isolation or seclusion; medical procedures or interventions performed without free and informed consent; invasive and irreversible surgical practices such as psychosurgery; and the forced administration of psychotropic drugs electroshock treatment.⁹
- 27. The AHRC welcomes the Productivity Commission's consideration of how workplaces, education, housing, social services and justice can contribute to improving mental health and economic participation and productivity. The AHRC recommends that the Productivity Commission also consider the following rights as part of the Inquiry:
 - e. **Access to Justice** (Article 13): this includes through the provision of procedural and age, gender and culturally appropriate accommodations and training for judicial staff.
 - f. **Living independently and being included in the community** (Article 19): this includes choices equal to others as to where to live and with whom. People with disability should not be obliged to live in a particular living arrangement, such as a psychiatric hospital or institutions.
 - g. **Education** (Article 24): people with disability have the right to inclusive education, at all levels and life-long learning.
 - h. **Work and employment** (Article 27): this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to people with disability.
 - i. **Adequate standard of living and social protection** (Article 28): people with disability have a right to an adequate standard of living for themselves and their families and a right to social protection and enjoyment of that right without discrimination on the basis of disability.

4.2 Key issues for people with disability

28. The AHRC is concerned that mental health laws, frameworks and policies in Australia permit or condone the provision of mental health services to people with psychosocial disability and mental health conditions in ways that breach their human rights. Outlined below are the areas of mental health laws, policies and practices that pose the most serious human rights concerns.

(a) Involuntary hospitalisation

29. State and territory mental health laws provide for involuntary hospitalisation or commitment of persons with psychosocial disability or mental health conditions via treatment orders. Involuntary hospitalisation is often justified by governments on the basis of preventing suicide and self-harm. However, studies have shown higher rates of suicide after psychiatric hospitalisation.¹⁰ Involuntary hospitalisation in mental health facilities constitutes a disability-specific form deprivation of liberty that contravenes the CRPD.
30. The CRPD Committee has called on Australia to repeal all legislation that authorises 'committal of individuals to detention in mental health facilities or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders'.¹¹

(b) Forced mental health interventions

31. Australian jurisdictions also permit the use of forced or otherwise coercive treatment on people with psychosocial disabilities or mental health. Evidence suggests the use of forced psychiatric treatment has increased in recent years¹² and that women are three times more likely to be subjected to the use of forced electroconvulsive therapy than men in Australia, across all age cohorts.¹³
32. Forced psychiatric interventions contravene the right of people with psychosocial disabilities and mental health conditions to be free from cruel, inhuman or degrading treatment (Article 15) and the right to treatment with free and informed consent (Article 25).
33. The CRPD Committee has called on Australia to 'repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities'.¹⁴ It has also called on Australia to 'take immediate steps to end [unregulated behaviour modification or

restrictive practices, such as chemical, mechanical and physical restraints and seclusions] ..., including by establishing an independent national preventive mechanism to monitor places of detention ... in order to ensure that persons with disabilities, including psychosocial disabilities or mental health conditions, are not subjected to intrusive medical interventions'.¹⁵

34. Human-rights compliant methods of providing support should replace coercive practices in mental health settings. The AHRC refers the Productivity Commission to the work of the Melbourne Social Equity Institute, University of Melbourne, which has undertaken an extensive literature review of alternatives to coercion in mental health settings.¹⁶
35. Beyond clinical mental health institutions, persons with psychosocial disabilities or mental health conditions can benefit significantly from a range of community-based support services that respect human rights, for example through the National Disability Insurance Scheme (NDIS). The AHRC welcomes the development of a new 'psychosocial disability stream' in the NDIS. However, the AHRC is concerned about the lack of support services available to people with psychosocial disability or mental health conditions who are ineligible for the NDIS.

(c) Substituted decision-making

36. People with psychosocial disability or mental health conditions may be subject to substitute decision-making regimes, which deny and restrict their legal capacity or use standards that focus on the 'best interests' of the person rather than their will and preferences. This includes mental health laws that permit treating psychiatrists to involuntarily admit and treat people with psychosocial disability or mental health conditions. It also includes guardianship regimes that permit a guardian to provide consent on behalf of a person with disability to mental health treatment, without that person's free and informed consent.¹⁷
37. Based on the CRPD Committee's interpretation of Article 12, Australia has an obligation to replace substituted decision-making regimes with decision-making support regimes. Decision-making supports comprise various supports which give primacy to a person's will, preferences and rights. The AHRC recommends that the Productivity Commission consider the National Decision-Making Principles recommended by the Australian Law Reform Commission in the *Equality Capacity and Disability in Commonwealth Laws* report. The AHRC also encourages the Productivity

Commission to consider the literature on the range of supports that can assist people with disability to exercise legal capacity in the mental health field.¹⁸ These include the use of mental health advance statements or directions, access to informal or peer support networks, and supported decision-making arrangements.

(d) Indefinite detention and diversions from the criminal justice system

38. People with psychosocial disability or mental health conditions may be found unfit to stand trial, or found non-liable or not criminally responsible due to 'insanity', 'unsound mind' or mental illness, and diverted to mental health or forensic facilities. These measures contravene Articles 13 and 14 of the CRPD.¹⁹
39. The 2016 Senate Community Affairs Reference Committee *Inquiry into Indefinite detention of people with cognitive and psychiatric impairment Australia* found that there were more than 100 people detained across Australia without conviction in prisons and psychiatric units under mental impairment legislation, and that at least 50 of these were Aboriginal and Torres Strait Islander people.²⁰
40. The CRPD Committee has urged Australia to ensure that people with psychosocial disabilities are 'ensured the same substantive and procedural guarantees as others in the context of criminal proceedings, and in particular to ensure that no diversion programs to transfer individuals to mental health commitment regimes or requiring an individual to participate in mental health services are implemented; rather, such services should be provided on the basis of the individual's free and informed consent'.²¹

4.3 Recommendations to improve the mental health of people with disability

41. **Recommendation 1:** The AHRC recommends that all Australian governments examine and reform mental health laws, frameworks and policies to ensure alignment with the CRPD. This includes implementing recommendations from the CRPD Committee to:
 - review all legislation that authorises involuntary hospitalisation or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders

- review all legislation that authorises medical intervention without the free and informed consent of the persons with disabilities
 - eliminate the use of restrictive practices, such as chemical, mechanical and physical restraints and seclusions
 - replace substituted decision-making regimes with decision-making support regimes, in line with the National Decision-Making Principles proposed by the Australian Law Reform Commission in the *Equality Capacity and Disability in Commonwealth Laws* report
 - ensure that people with psychosocial disability have the procedural guarantees as others in the context of criminal proceedings.
42. The CRPD Committee will consider Australia's second and third reports under the CRPD in September 2019.
43. **Recommendation 2:** The AHRC recommends that the Productivity Commission consider the CRPD Committee's concluding observations on these reports, which are expected to be released in October 2019.

5 Children and young people

5.1 *Convention on the Rights of the Child*

44. The *Convention on the Rights of the Child* (CRC) provides the international human rights framework for the protection, promotion and fulfilment of rights of children and young people. The guiding principles of the CRC are non-discrimination, the best interests of the child, participation of the child, and ensuring the child's survival and development. Together, the CRC and CRPD provide the human rights standards applicable to children with psychosocial disabilities or mental health conditions.
45. The AHRC recommends that the Productivity Commission consider the rights of children in its inquiry, in particular Article 25 and Article 19 under the CRC.
46. Article 24 provides that:

'States Parties recognize 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 of access to such health care services.'²²

47. In all matters relating health care and services, Australia must ensure that children have the right express their views, will and preferences freely in respect of all health-related matters affecting them (with the provision of disability and age-appropriate assistance), and for these views to be given due weight in accordance with their age and maturity.²³
48. Article 19 provides that:

'States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment...'²⁴

49. The United Nations Committee on the Rights of the Child has noted that mental health problems, including suicide attempts, are widely recognised as 'health consequences of violence against children and child maltreatment'.²⁵

5.2 Key issues for children and young people

50. In 2017, Mission Australia with the Black Dog Institute released a joint *Five-Year Youth Mental Health Report* about the mental health of Australia's young people (15–19 years) during the period 2012 to 2016. Its findings include:
 - almost one in four young people met the criteria for a serious mental illness, increasing from 18.7% in 2012 to 22.8% in 2016
 - females were twice as likely to meet these criteria than males
 - the likelihood of probable serious mental illness was found to be consistently higher among Aboriginal and Torres Strait Islander young people compared to their non-Indigenous peers
 - the key issues were depression, stress, body image and school issues
 - the main sources of help reported were friends, parents and the internet.²⁶
 - **Suicide and self-harm**

51. The National Children's Commissioner conducted an investigation into youth suicide and intentional self-harm in 2014 and has continued to monitor developments in this area. This study revealed that more than one child every week takes their own life and that 50-60 were admitted to hospital each week in the context of self-harming incidents. Information obtained from the Kids Helpline for 2012-2013 showed that mental health issues was the top co-presenting concern when children contacted the helpline about suicide or self-harm.
52. The study also found significant increases in the rates of suicide between those aged 11– 12 and 13– 14 years of age, pointing to the need for early intervention in identifying and responding to mental health issues, and building resilience and protective factors. Further details about this project are available in the *Children's Rights Report 2014*:
<https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014>.
53. More current data about youth suicide and intentional self-harm was included in the report that the AHRC made to the United Nations Committee on the Rights of the Child on Australia's progress in meeting its obligations under the CRC. This information was provided to the AHRC by the National Coronial Information System and the Australian Bureau of Statistics. Suicide remained the leading cause of death of children between five and 17 years of age in 2017 and the number of hospitalisations for self-harming in children aged between three and 17 years almost doubled between 2007–2008 and 2016–2017.
54. Further, the National Mental Health Commission indicated (in a submission to the AHRC for the 2018 Report to the Committee) that there is a shortage of youth-focused mental health services in Australia. This can result in children and young people presenting later or at a more advanced stage of ill-health. It is imperative that there is a national approach to mental health and that this approach prioritises the distinct mental health needs of Australian children and young people.

(a) Aboriginal and Torres Strait Islander children and young people

55. Aboriginal and Torres Strait Islander children and young people are overrepresented in both suicide and self-harm data.²⁷ Supporting the mental health needs of Aboriginal and Torres Strait Islander children and young people should therefore be an urgent priority for all governments.

56. The Australian Bureau of Statistics has reported that, in 2017, Aboriginal and Torres Strait islander children aged between five and 17 died from suicide-related deaths at five times the rate of non-Indigenous children.
 - The age-specific death rate for Aboriginal and Torres Strait Islander children and young people was 10.1 deaths per 100,000 persons, compared to 2.0 per 100,000 for non-Indigenous persons.
 - Suicide remained the leading cause of death for both Aboriginal and Torres Strait Islander and non-Indigenous children and young people, accounting for 40% of all Indigenous child deaths.²⁸
57. The reasons for the overrepresentation of Aboriginal and Torres Strait Islander children and young people in statistics about intentional self-harm with or without suicidal intent are complex and multifactorial in nature. They include the legacy of colonisation, inter-generational trauma and ongoing racism, combined with the effects of unemployment, poverty, overcrowded housing conditions, exposure to domestic violence, social marginalisation and access to alcohol and drugs.
58. The immediate influences on poor social and emotional wellbeing and high youth suicide rates for Aboriginal and Torres Strait Islander peoples include:
 - a lack of culturally appropriate social and emotional wellbeing services that are focused on prevention and early intervention as well as responding to crisis
 - inadequate support to address the complex needs of children and adults living with conditions such as fetal alcohol syndrome
 - homelessness caused by poverty and domestic violence
 - punitive social security and justice systems
 - substance abuse, and
 - physical and sexual violence.
59. Recent consultations with Aboriginal and Torres Strait Islander young women and girls, conducted by the AHRC as part of the Wiyi Yani U Thangani project, have identified experiences of racism as a particularly significant issue for young girls.²⁹

(b) Sexuality diverse, transgender, gender diverse and intersex children and young people

60. The *Growing Up Queer* report, released by the Young and Well Cooperative Research Centre in 2014, identified intentional self-harm and suicide as an issue for children and young people who are sexuality diverse, transgender, gender diverse and intersex.³⁰ As part of this report, an online national survey completed by 1,032 children and young people aged 16–23 years found that 41% of participants had thought about self-harm and/or suicide, 33% had harmed themselves, and 16% had attempted suicide.³¹

(c) Children and young people from culturally and linguistically diverse (CALD) backgrounds

61. There is limited data about the prevalence of mental health conditions or self-harm within CALD communities. However, commentators suggest that children and young people from CALD backgrounds may be particularly vulnerable to environmental risk factors that impact negatively on their mental health. One issue for children from CALD backgrounds, according to the Department of Health, is that ‘they have a significantly lower level of access to mental health care and support in the wider community’.³²
62. In a submission made to the AHRC in 2014, the Centre for Multicultural Youth identified traumatic experiences prior to immigration, the stresses of migration, separation from families and communities, settlement in a new country, being ‘caught’ between cultures, low language proficiency, higher levels of social disadvantage and unemployment as issues faced by children from CALD communities.³³
63. Some children and young people from CALD backgrounds also experience racism at school and in the broader community, which can lead to feelings of isolation and trigger pre-migration trauma (which refers to the trauma experienced by immigrants/refugees/asylum seekers in their country of origin prior to arriving in Australia, such as violence and persecution³⁴).

(d) Regional inequality

64. Through a series of consultations with children, the National Children’s Commissioner has identified that service delivery, access to new

technologies and infrastructure, and access to adequate healthcare, education and housing vary significantly between cities, regional and remote areas. The National Children's Commissioner also found that children in regional and remote areas do not enjoy the same opportunity to thrive as other children.³⁵

65. Children who lived in remote areas were also more likely to die due to intentional self-harm than by other external causes, compared to children who lived in metropolitan areas.³⁶ Data on hospitalisations for intentional self-harm in children aged 3–17 years in regional and remote areas accounted for 38% of all hospitalisations between 2007–2008 and 2012–2013.³⁷

(e) Exposure to violence and abuse

66. Children's personal experiences of violence and abuse have a profound effect on their mental health. The National Children's Commissioner's 2014 investigation found a connection between exposure to family conflict and violence and self-harm and suicide among children. For example, information provided by Kids Helpline showed that in 21% of contacts about suicide, family conflict and violence were co-presenting concerns.
67. In a subsequent investigation in 2015, the National Children's Commissioner found that one in every 12 people first experienced physical abuse as a child before the age of 15, perpetrated by a family member, and one in every 28 people experienced sexual abuse as a child before the age of 15, perpetrated by a family member. The widespread abuse of children is further emphasised in child protection data, which shows that 49,315 children were the subjects of substantiated reports of abuse and neglect in 2016–17.³⁸
68. The *Royal Commission into Institutional Responses to Child Sexual Abuse* also revealed that organisational cultures within Australia led to both the large-scale abuse of children, and poor institutional responses to complaints of such abuse. In order to reduce the incidence of mental illness in children and young people, we must address the cultural norms surrounding violence and abuse and limit children's exposure to such phenomena.

5.3 Recommendations to improve the mental health of children and young people

69. In the *Children's Rights Report 2014*, the National Children's Commissioner made a series of recommendations that are relevant to the Productivity Commission's Inquiry.
70. **Recommendation 3:** That the Australian Government establish a national research agenda for children and young people engaging in non-suicidal self-harm and suicidal behaviour.³⁹ This research agenda should prioritise:
 - the standardisation of terms and definitions to describe the range of thoughts, communications, and behaviours that are related to intentional self-harm, with or without the intent to die
 - understanding the multiplicity of risk factors central to effectively targeting and supporting children and young people
 - understanding the impact of different protective factors, how they are interrelated, whether some are more predominant than others, or whether specific combinations offer more protection
 - the direct participation of children and young people in research about intentional self-harm, with or without suicidal intent
 - understanding the psychological mechanisms underlying suicide clusters
 - understanding incidence and mechanisms leading to clustering of intentional self-harm without suicidal intent
 - evaluating the effectiveness of postvention services
 - evaluating the effectiveness of gatekeeping training programs on actual outcomes for children and young people
 - increasing the awareness of primary caregivers about risk factors and warning signs
 - investigating ways to restrict access to the means used for intentional self-poisoning in children and young people
 - finding effective ways to encourage children and young people to access appropriate help or support for early signs and symptoms of difficulties

71. **Recommendation 4:** that the Australian Government strengthen and develop surveillance of intentional self-harm, with or without suicidal intent,⁴⁰ through:
 - The Australian Government funding an annual report on deaths due to intentional self-harm involving children and young people aged 0-17 years using the agreement reached between the Australian Bureau of Statistics; the Registrars of Births, Deaths and Marriages; and state and territory coroners on the dissemination of unit record data.
 - The Australian Institute of Health and Welfare including a section using disaggregated data about hospitalisations for intentional self-harm involving children and young people aged 0-17 years in its regular series on hospitalisations for injury and poisoning in Australia.
 - The Australian and New Zealand Child Death Review and Prevention Group continuing its work in relation to the development of a national child death database, in conjunction with the Australian Institute of Health and Welfare, and providing an annual progress report.
72. **Recommendation 5:** that the Australian Government collect national data on children and young people who die due to intentional self-harm through the use of the standardised National Police Form, in all jurisdictions, by 2015. This should include an electronic transfer to the National Coronial Information System. A plan to monitor the outcomes of all jurisdictions using the standardised National Police Form should be developed, and the possibility of incorporating a range of demographic, psychosocial and psychiatric information specific to children and young people should be investigated.⁴¹
73. **Recommendation 6:** that the Australian Government develop a national plan for child wellbeing, using the CRC as its foundation.
74. **Recommendation 7:** that the Australian Government increases prevention measures and responses to family violence that address the distinct impacts on children.
75. **Recommendation 8:** that the Australian Government expands and funds the delivery of child-targeted mental health and other necessary support services.
76. **Recommendation 9:** that the Australian Government provides appropriate and specific physical and psychological rehabilitation for all children arriving in or returning to Australia who may have been involved in armed conflict.

77. **Recommendation 10:** that the Australian Government develop a national children's data framework to ensure appropriate data collection that supports policy making on child rights issues.⁴²

6 Aboriginal and Torres Strait Islander peoples

6.1 *United Nations Declaration on the Rights of Indigenous Peoples*

78. The Australian Government adopted the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) in 2009. The UNDRIP must be considered alongside the CRPD when considering the rights of Aboriginal and Torres Strait Islander people with psychosocial disability or mental health conditions, in particular Article 24 and Article 23 of the UNDRIP.
79. Article 24(2) of the UNDRIP provides that:

'Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health.'

80. This article should be read in conjunction with Article 23, which provides that:

'Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.'

81. The underlying principles of the UNDRIP guide how these rights are brought into effect. The four main principles of the UNDRIP are:
- self-determination
 - effective participation in decision-making underpinned by free and informed consent
 - non-discrimination and equality
 - respect for protection of culture.

6.2 Key issues for Aboriginal and Torres Strait Islander Peoples

(a) Trauma, disadvantage, institutional racism and inequality

82. Any effective strategy to address the Aboriginal and Torres Strait Islander mental health must address both the immediate safety of Aboriginal and Torres Strait Islander peoples and the root causes of poor mental health including intergenerational and contemporary experiences of trauma, ongoing powerlessness, poverty and disadvantage, all of which are linked to institutional racism and entrenched inequality.
83. Institutional racism manifests itself through the continued marginalisation of Indigenous voices from political structures, the way institutions operate without due regard for cultural difference, and the lack of adequate measures to allow for Aboriginal and Torres Strait Islander peoples to have meaningful access to appropriate services.
84. Despite the Australian Government's adoption of UNDRIP, political systems and institutions remain inadequate in providing Aboriginal and Torres Strait Islanders with a voice in the matters that affect their lives. This has undermined governments' capacity to deliver positive social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander peoples.

(b) Self-determination, healing and community driven approaches

85. Giving full effect to UNDRIP will necessitate an accommodation of Indigenous self-determination within the political system, and a space for truth-telling and healing, the need for which are expressed in the Uluru Statement from the Heart. It will also necessitate the observance of key principles in the carriage of service delivery.
86. Australia's Indigenous health policies are guided by the *National Aboriginal and Torres Strait Islander Health Plan* principles. These guiding principles ask that governments adopt a holistic approach to Aboriginal and Torres Strait Islander health policy, and recognise that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance.⁴³
87. When these principles are successfully applied, this has a significant and positive impact on communities, as has been demonstrated, for example, by the National Healing Foundation's trauma-informed programs which

are based on pre-existing Aboriginal and Torres Strait Islander-specific frameworks. Indeed, evidence globally suggests that the wellbeing of Indigenous People requires the foundation of connection to traditional culture and practice.⁴⁴

88. Services continue to be provided through a mainstream perspective that is ill-equipped to deliver on the cultural relevance and needs required to deliver effective outcomes. Better outcomes will require a marked change to the status quo. The Aboriginal and Torres Strait Islander Social Justice Commissioner, June Oscar has said:

'The foundation to First Peoples achieving better outcomes must be centred around the abiding strength of our diverse cultures, our ceremonies, our language, our country. Cultural continuity, or "being who we are", is foundational to our health... Our land is where our people need to be able to draw positive emotions, meaning and purpose, emotional stability, self-esteem and resilience. Land, language and culture go hand in hand. Language is the vehicle to transmit cultural strengths and positive messages about our Aboriginality from generation to generation.'⁴⁵

89. Culturally-anchored community-driven approaches are the key to long-term success. Empowered societies not only bring about more effective social and emotional wellbeing solutions, the act of exercising agency, in and of itself, promotes social and emotional wellbeing.
90. To see real change, governments must invest over the long-term in community-led programs. Currently, funding is generally short-term, ad hoc and fragmented across government departments.

6.3 Recommendations to improve the mental health of Aboriginal and Torres Strait Islander peoples

91. **Recommendation 11:** that Australian governments invest in the identification and provision of culturally appropriate services to Indigenous children and young people in crisis situations.
92. **Recommendation 12:** that Australian governments work in partnership with Indigenous peoples and organisations to build upon the findings of the *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project* (ATSiSPEP) to empower communities to lead their own solutions.

93. **Recommendation 13:** that Australian governments build upon the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* by working in partnership with Indigenous peoples and organisations to develop a renewed Strategy and fully-funded Implementation Plan with a focus on preventing child and youth suicide.⁴⁶
94. The renewed strategy should focus on supporting community-led solutions, increasing the Indigenous social and emotional wellbeing workforce, and supporting community-controlled health services to deliver an integrated range of trauma-informed and culturally safe services through the provision of sustainable funding.
95. **Recommendation 14:** that the Council of Australian Governments work with the Coalition of Peaks to develop social and emotional wellbeing and suicide prevention targets and indicators within the refreshed Closing the Gap Strategy.

¹ Sections 11(1) (g) and (h) of the *Human Rights Commission Act 1986* (Cth) provide that the Commission include promoting “an understanding and acceptance, and the public discussion, of human rights in Australia” and undertaking “research and educational programs and other programs, on behalf of the Commonwealth, for the purpose of promoting human rights, and to co-ordinate any such programs undertaken by any other persons or authorities on behalf of the Commonwealth”.

² Australian Human Rights Commission, *Children’s Rights Report 2014* (2014) 133 <<https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014>>.

³ The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Media Release: Indigenous Leaders Call Australian Governments to Action on Indigenous Child and Youth Suicide*, 25 March 2019 at <https://www.cbpatsisp.com.au/indigenous-leaders-call-australian-governments-to-action-on-indigenous-child-and-youth-suicide/>

⁴ Human Rights Council, ‘Resolution Adopted by the Human Rights Council on 28 September 2017 - Mental Health and Human Rights’ (A/HRC/Res/36/13, 9 October 2017).

⁵ Human Rights Council, above n 4, 4.

⁶ Human Rights Council, above n 4, 4.

⁷ Human Rights Council, above n 4, 4–5.

⁸ Human Rights Council, above n 4, 2.

⁹ Committee on the Rights of Persons with Disabilities, ‘General Comment No.3 (2016) on Women and Girls with Disabilities’ (CRPD/C/GC/3, 25 November 2016) 34.

¹⁰ Daniel Thomas Chung et al, ‘Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-Analysis’ (2017) 74(7) *JAMA Psychiatry* 694; Domenico Giacco and Stefan Priebe, ‘Suicidality and Hostility Following Involuntary Hospital Treatment’ 11(5) *PLoS ONE* e0154458; C Katsakou and S Priebe, ‘Outcomes of Involuntary Hospital Admission – a Review’ (2006) 114(4) *Acta Psychiatrica Scandinavica* 232.

¹¹ Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session' (CRPD/C/AUS/CO/1, 21 October 2013) 34.

¹² Australian Cross Disability Alliance, 'Submission - Senate Community Affairs Reference Committee - Inquiry into Violence, Abuse and Neglect against People with Disability In Institutional Settings' (August 2015) 35 <<http://dpoa.org.au/acda-submission-senate-inquiry-violence-abuse-neglect-people-disability-institutional-residential-settings/>>.

¹³ Women with Disabilities Australia, 'Submission to the Preparation Phase of the UN Analytical Study on Violence against Women and Girls with Disabilities' (A/HRC/RES/17/11, 2011) <<http://www.wwda.org.au/WWDASubUNStudyViolenceWDDec2011.pdf>>.

¹⁴ Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session', above n 11, 34.

¹⁵ Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session', above n 11, 36.

¹⁶ Piers Gooding et al, 'Alternatives to Coercion in Mental Health Settings: A Literature Review' (Melbourne Social Equity Institute, University of Melbourne, 2018) <https://socialequity.unimelb.edu.au/_data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf>.

¹⁷ Committee on the Rights of Persons with Disabilities, 'General Comment No.1 (2014) - Article 12: Equal Recognition before the Law' (CRPD/C/GC/1, 19 May 2014) 41. 41.

¹⁸ See for example George Szmukler, "Capacity", "Best Interests", "Will and Preferences" and the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) *World Psychiatry* 34; Dainius Puras and Piers Gooding, 'Mental Health and Human Rights in the 21st Century' (2019) 18(1) *World Psychiatry* 42; Piers Gooding author, *A New Era for Mental Health Law and Policy Supportive-Decision Making and the UN Convention on the Rights of Persons with Disabilities* (Cambridge University Press, 2017); Penelope Weller author, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Routledge, 2013); Bernadette McSherry and Penelope Weller, *Rethinking Rights-Based Mental Health Laws* (Hart Pub, 2010).

¹⁹ Office of the United Nations High Commissioner for Human Rights, 'Right to Access Justice under Article 13 of the Convention on the Rights of Persons with Disabilities' (27 October 2017).

²⁰ Senate Community Affairs Reference Committee, 'Inquiry into Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia Report' (29 November 2016) <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/IndefiniteDetention45/Report>.

²¹ Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session', above n 11, 29.

²² Convention on the Rights of the Child.

²³ Above n 22, art 12.1; Convention on the Rights of Persons with disabilities, art 7.3.

²⁴ Above n 22.

²⁵ *Committee on the Rights of the Child, General Comment No. 13 – The right of the child to freedom from all forms of violence*, CRC/C/GC/13 (2011), 7 and 21. <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fGC%2fGC%2f13&Lang=en>.

²⁶ Mission Australia, *Youth Survey Report 2017* (2017) 4

<<https://www.missionaustralia.com.au/publications/research/young-people>>.

²⁷ Australian Human Rights Commission, *Information relating to Australia's joint fifth and sixth report under the Convention on the Rights of the Child, second report on the Optional Protocol on*

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²⁸ Australian Bureau of Statistics, *Causes of Death, Australia, 2017: Intentional self-harm in Aboriginal and Torres Strait Islander People* at
[<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~10>](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~10)

²⁹ Ms June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner, 'No Woman Left Behind Conference – International Women's Day' (Speech, 8 March 2019)
[<https://www.humanrights.gov.au/news/speeches/no-woman-left-behind-conference-international-womens-day>](https://www.humanrights.gov.au/news/speeches/no-woman-left-behind-conference-international-womens-day).

³⁰ Kerry Robinson, Peter Bansel, Nida Denson, Georgia Ovenden and Cristyn Davies, *Growing Up Queer: Issues facing young Australians who are gender variant and sexuality diverse* (February 2014) Young and Well Cooperative Research Centre
[<https://www.glhv.org.au/sites/default/files/Growing_Up_Queer2014.pdf>](https://www.glhv.org.au/sites/default/files/Growing_Up_Queer2014.pdf).

³¹ Robinson, above n 30.

³² Australian Government Department of Health, *Fact sheet: Mental health services for people of culturally and linguistically diverse (CALD) backgrounds* (3 September 2018)
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³³ The Centre for Multicultural Youth, *Mind Matters: The mental health and well-being of young people from diverse cultural backgrounds* (2014) <<http://cmy.net.au/publications/mind-matters>>; Dr Erminia Colucci, Submission 104 <www.humanrights.gov.au/publications/childrens-rights-report-2014>.

³⁴ Norris, A. E., Aroian, K. J., and Nickerson, D. M., 'Premigration Persecution, Postmigration Stressors and Resources, and Postmigration Mental Health: A Study of Severely Traumatized U.S. Arab Immigrant Women' (2011) 17 *Journal of the American Psychiatric Nurses Association* 4: 283–296 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4464810/>>.

³⁵ Australian Human Rights Commission, *Children's Rights Report 2013* (2013) 94
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³⁶ Australian Human Rights Commission, above n 35.

³⁷ Australian Human Rights Commission, above n 35.

³⁸ Australian Institute of Health and Welfare, *Child Protection Australia 2016–17* (Report, 9 March 2018) 23 <<https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2016-17/notices>>.

³⁹ Australian Human Rights Commission, above n 35.

⁴⁰ Australian Human Rights Commission, above n 35.

⁴¹ Australian Human Rights Commission, above n 35.

⁴² Australian Human Rights Commission, *Information relating to Australia's joint fifth and sixth report under the Convention on the Rights of the Child, second report on the Optional Protocol on the sale of children, child prostitution and child pornography, and second report on the Optional Protocol on the involvement of children in armed conflict* (Report, 1 November 2018)
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⁴³ The Department of Health Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*:

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⁴⁴ Purdie N, Dudgeon P, Walker R, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (First Edition), 2010, Australian Council for Educational Research (ACER). At http://research.acer.edu.au/indigenous_education/24/ (viewed 26 October 2017).

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