Australian Human Rights Commission

National Children's Commissioner

Megan Mitchell

Productivity Commission

4 National Circuit

Barton

ACT, 2600

Re: Comments on Draft Mental Health Report

20 January 2020

Dear Sir/Madam,

Thank you for the opportunity to provide comments on the Productivity Commission's Draft Report on Mental Health, 2019. Understanding and supporting the mental health and wellbeing of children and young people has been an important priority area for me during my term as National Children's Commissioner.

The draft report prepared by the Productivity Commission in response to its Inquiry into Mental Health provides a comprehensive analysis of many of the key issues experienced by children and young people in relation to their mental health and wellbeing and highlights the social and economic costs of inaction or ineffective intervention.

In particular, it addresses the significance of suicide and intentional self-harm among children and young people, topics that I conducted a special investigation into in 2014, and which I continue to monitor.

The 2014 investigation arose as a result of concerns raised with me by members of the community, including children themselves. The full results of this investigation are contained in Chapter 3 of my statutory report to the Australian Parliament, which is available here: https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014.

This investigation was informed by an analysis of available primary and secondary research, submissions from experts and advocates in the area of child mental health, sourcing of available data and the perspectives of children and young people themselves.

The data showed that intentional self-harm was the leading cause of death among Australian children and young people aged 15-24 years[1]and that self-harm was a very significant, albeit undercounted, issue. It also showed that Aboriginal children made up 20% of suicides despite being just under 6% of the youth population, and nearly 80% of suicides in the younger cohorts.[2] A critical finding was that that the biggest jump in suicides was between the ages of 12/13 and 13/14, at a time when children are making a significant transition from primary to high school, experiencing puberty and a second phase of rapid brain development.[3]

This tells me that we need to intervene much earlier in identifying risk factors and mental health concerns and building protective and help seeking behaviours.

I concluded that much remains to be done in the area of intentional self-harm, with or without the intention to die, for children and young people.

And while we have some understanding of these phenomena, there is too much that we still do not know. This limits our capacity to respond effectively to the mental health needs of children and prevent children and young people from engaging in non-suicidal self-harm and suicidal behaviour.

Fundamentally, we lack an accurate means of predicting these behaviours and an effective method of preventing them.[4]

This is compounded by the complexities inherent in data collection and the restricted access to data that is collected.

Establishing a national research agenda is the first step in providing a structure for moving forward. Standardisation of coronial legislation and/or coronial systems in Australia, and all jurisdictions using the standardised National Police Form, will also assist with data collection.

A summary of key findings from my 2014 report is set out below:

The inconsistent use of terms and definitions to describe the range of thoughts, communications, and behaviours that are related to non-suicidal self-harm, suicidal behaviours and death due to intentional self-harm.

These definitional issues present significant challenges for those working in the field. Researchers cannot easily compare their study populations and research findings, and clinicians have difficulty translating research findings into practical applications.[5] Differentiating self-harm with and without suicidal intent is essential for building precise understandings of these behaviours, as well as how non-suicidal self-harm relates to, and influences, suicidality.[6]

Neither the ICD-10 codes nor the classification system used by National Coronial Information System (NCIS) distinguish between intentional self-harm with suicidal intent and intentional self-harm without suicidal intent. Conflating intentional self-harm with suicidal intent and intentional self-harm without suicidal intent makes it difficult to construct an accurate picture of what is actually occurring.[7]

Understanding the multiplicity of risk factors is central to effectively targeting and supporting children and young people.[8]

While there is a growing body of knowledge about the risk factors that increase the likelihood of suicidal behaviour and non-suicidal self-harm, much less is known about how or why they engage in these behaviours.[9]

We do not know whether they develop as a result of multiple, interrelated risk factors or only one or two predominant vulnerabilities, or whether specific combinations of risk factors can accurately predict intentional self-harming behaviour with or without suicidal intent.[10]

Suicidal thoughts and fears were the predominant concerns raised by children and young people who identified suicide as their primary concern with the Kids Helpline, with the top co-presenting concerns being mental health and anxiety. Talking through the consequences and/or alternative coping strategies were the foremost concerns of children and young people who identified self-injury and self-harm as their primary concern.

Building knowledge about this 'will help us to start to make sense of the many risk factors that have been identified, and will yield the most clinically useful information'. Currently, 'most studies examine bivariate, linear associations between individual risk factors and self-harm'. Research that simultaneously considers multiple risk factors is required.[11] Domestic and family violence has also been raised as a particular risk factor requiring further research.

Similarly, while knowledge about possible protective factors is increasing, we do not sufficiently understand the impact of the different protective factors, how they are interrelated, whether some are more predominant than others or whether specific combinations offer more protection.

There is a dearth of research involving the direct participation of children and young people.

The National Statement on Ethical Conduct in Human Research guides research in this area.[12] Recent studies have shown that participation in research related to suicide prevention appears to have no iatrogenic effects among participants. Research proposals to Ethics Committees should highlight this.

Empirical evidence is lacking in terms of the psychological mechanisms underlying suicide clusters.[13]

Overall, the risk factors for cluster suicide are not dissimilar from those associated with individual adolescent suicide.[14] This means they are not particularly helpful in assisting to identify those children and young people who may be most at risk of becoming part of a suicide cluster.[15]

It has been suggested that psychological mechanisms may include contagion, imitation, suggestion, social learning theory and assortative relating, but 'there is no firm evidence that these mechanisms operate in cluster formation. It would seem reasonable to infer that multiple mechanisms operate together, and that the main mechanism is different for different settings and populations. Which mechanism, if any, is dominant in any particular cluster is unknown'.[16]

There is limited evidence about the incidence and mechanisms leading to clustering of intentional self-harm without suicidal intent.

There is no solid evidence base documenting the effectiveness of postvention services.

A review of the literature on postvention strategies delivered to children and young people in response to suicide clusters concluded that, with so few evaluations of postvention responses, it was difficult to draw firm conclusions about the effectiveness of these strategies on the reduction of suicide risk or death due to intentional self-harm[17].

The general lack of evaluation of programs, strategies, and services was also raised in the *Evaluation Report of the National Suicide Prevention Program* published in 2014.[18] The report noted that a lack of outcome data made it difficult for projects to demonstrate their effectiveness.

There is insufficient empirical evidence on the effectiveness of gatekeeping training programs on actual outcomes for children and young people.[19]

The Menzies School of Health Research indicated in a submission to me that 'there is almost no reported evidence of its effectiveness in reducing risk factors in young people'[20]. Determining the effectiveness of gatekeeper training programs on the outcomes for children and young people should be prioritised in evaluations of these programs and also in future research.

Where children and young people present to an accident and emergency department, there is a genuine opportunity to connect with them and facilitate follow-up intervention.

Not enough is known about the online communicability of non-suicidal self-harm, including examinations of the processes by which communications initiate, reinforce, and/or help to extinguish non-suicidal self-harm[21].

Poorly completed death certificates impede the accurate identification of intentional self-harm resulting in death by suicide. Some roundtable participants and submissions from the Australian Capital Territory raised this issue.

Given the prevalence of hanging, investigating ways to prevent it should be prioritised.

The data provided by the NCIS and the Australian Bureau of Statistics (ABS) confirmed that hanging was the most frequently used mechanism of intentional self-harm leading to death in children and young people across all age ranges. According to the NCIS, 89% of children and young people aged 4-13 years died by hanging. 80% of those aged 14-15 years and 81% of those aged 16-17 years died by hanging.[22]

While hanging has been predominantly associated with males, it is now the most common mechanism used by females. Previously, suicide prevention has focused on restricting access to particular methods (such as firearms or paracetomol). Unfortunately, restricted access to the means for hanging is not possible. Detailed research is required to verify existing perceptions about hanging and to explore in detail how these perceptions influence children and young people when planning a suicide attempt.[23]

Increasing the awareness of primary caregivers about risk factors and warning signs is essential.

The NCIS data showed that 76% of deaths in children and young people were due to intentional self-harm occurring in the home.[24]

The continued implementation of universal suicide prevention strategies aimed at raising public awareness, encouraging help-seeking behaviour and challenging stigma associated with suicide may assist with this.

The submission from the Black Dog Institute highlighted that the community has 'low to moderate levels of suicide literacy, with the greatest deficits in the identification of the signs and symptoms of suicide and the risk factors associated with it'[25]. The Black Dog Institute also emphasised that 'Family and friends have poor knowledge of the signs of suicide and lack knowledge about how and in what circumstances they should act'.[26]

Restricting access to the means used for intentional self-poisoning could prevent intentional self-harm in children and young people.

The data provided by AIHW showed that there were 18,277 hospitalisations for intentional self-harm in children and young people aged 3-17 years between 2007-2008 and 2012-2013. 82% of these hospitalisations were due to intentional self-poisoning. Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics was the most frequently used means, followed by antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified, and then by other and unspecified drugs, medicaments and biological substances.[27] Restricting access to means is known to be an effective suicide prevention strategy.

Finding effective ways to encourage children and young people to access appropriate help or support for early signs and symptoms of difficulties must be a priority.[28]

headspace stated:

> 'If the barriers to help-seeking can be addressed, young people experiencing emotional distress are more likely to access help earlier when difficulties first arise. This can help prevent more serious long-term problems from developing, including deliberate self-harm and suicidal behaviours, which may then be more difficult to treat or require more intensive interventions.'[29]

This includes equipping peers to support each other.

Many children and young people seek help from the Kids Helpline, in particular. The importance of these anonymous confidential helplines for children staffed by skilled professionals and available 24/7 cannot be underestimated. Of the 80,142 contacts during 2012 and 2013 from children and young people aged 5-17 years, which involved the provision of counselling,[30] 11,180 contacts were assessed by counsellors as involving a child or young person with current thoughts of suicide,[31] and 18,737 contacts were assessed by counsellors as involving a child or young person who self-injures and self-harms.[32] There were significantly fewer contacts to Kids Helpline made by male children and young people compared with contacts made by female children and young people.

Knowing how, when and why children and young people prefer to make contact is essential for tailoring services to their needs. More research that directly involves children and young people is required in this area.

Where contact was made to Kids Helpline about suicide with other concerns, self-injury and self-harm was one of the other main concerns. Where contact was made about self-injury and self-harm, one of the other frequently cited concerns was suicide.

Suicidal thoughts and fears were the predominant concerns raised by children and young people who identified suicide as their primary concern. Talking through the consequences and/or alternative coping strategies were the foremost concerns of children and young people who identified self-injury and self-harm as their primary concern.

Regardless of whether the main contact was about suicide or self-injury and self-harm, the leading co-concerns raised by children and young people were about mental health, child-parent/family relationships and emotional wellbeing.

This type of information is invaluable and should inform the ways that resources and interventions are developed and targeted to children and young people.[33]

Recommendations from the Children's Rights Report 2014:

I made the following recommendations based on the public health model, where suicide prevention begins with surveillance to define the problem and to understand it, followed by the identification of risk and protective factors (as well as effective interventions), and culminates in implementation, which includes evaluation and scale-up of interventions and leads to revisiting surveillance and the ensuing steps.[34]

1. **Establish a national research agenda for children and young people engaging in non-suicidal self-harm and suicidal behaviour. 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.

2. **Strengthen and develop surveillance of intentional self-harm, with or without suicidal intent, through:**

    a) 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.

    b) 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.

c) 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.

3. **Collect national data on children and young people who die due to intentional self-harm through:**

   a) 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.

   b) The Standing Council on Law, Crime and Community Safety putting the issue of standardisation of coronial legislation and/or coronial systems on its agenda. Standardisation should require that where all state and territory coroners find a death under investigation to be caused by an action of the deceased, the coroner must make a further finding of intent, based on the evidence, to clarify whether the deceased intended to take the action which caused his or her death; the deceased lacked capacity to recognise that his or her action would cause his or her death but death was a reasonably foreseeable consequence of the action; or it is not clear from the evidence whether the deceased intended to cause his or her death.

4. **The Royal Australian and New Zealand College of Psychiatrists should review and, where appropriate, update its Guidelines for the Management of Deliberate Self Harm in Young People (2000).**

I have continued to monitor trends and developments in this area and last year I included the latest available data on the mental health needs of children in my report to the United Nations Committee on the Rights of the Child. In February 2020, I will be releasing a comprehensive report on the state of child rights in

Australia which includes considerable data and recommendations in relation to addressing child mental health. In November 2019, I released *Children's Rights in Australia: A scorecard*, which provides a snapshot of key information relating to children's rights in the context of mental health.

Taking a rights perspective to child mental health allows us to see the totality of the child, their needs and circumstances.

Under the *Convention on the Rights of the Child*, Australia has committed, among other things, to delivering to children:

- The highest standard of health and to facilities and for the treatment of illness and rehabilitation (article 24)
- Protection from violence and abuse in all aspects of their lives, including that which is self-inflicted (article 19)
- An education (articles 28 and 29)
- Survival and development (article 6).[35]

Relevant findings relating to children's mental health include:

- In 2017, suicide was the leading cause of death among people aged between 15–44 years.[36]
- In 2016–17, 7,571 children and young people aged 0–19 years were admitted to hospital for self-harming behaviour (between 2007 and 2017 three were 35,997 hospitalisations of children aged 3-17 for intentional self-harm)[37].
- 1 in 7 children and young people aged 4-17 were assessed as having a mental health disorder (2013/14)[38], and 4 in 10 young people aged 15-19 identified mental health as a top issue.[39]
- In 2018, the Kids Helpline responded to 67,264 contacts from children and young people aged 5-25 seeking counselling support, with 27% of these in relation to mental health concerns.[40]

In addition to my 2014 recommendation about the need for a national research agenda into suicide and self-harm among children, in my 2018 report and 2019 scorecard I recommended that**:**

The Australian Government should expand and fund the delivery of child targeted mental health and other necessary support services.

Below, I specifically address particular issues and recommendations raised in the Commission's draft report and also point to a number of issues that are not directly addressed, and which I hope the Productivity Commission will consider when finalising its report.

National planning:

Recommendations to strengthen national planning and co-ordination in relation to child mental health are supported. This should be accompanied by quarantined commissioning and resourcing for mental health intervention across the service spectrum (including Primary Healthcare Networks).

Data and research:

The Productivity Commission's draft report notes that Australia is data rich but information poor. While, in respect to child wellbeing, I agree with this statement to some extent, there remains considerable missing data and information in relation to child wellbeing and, in particular, their mental health.

Before I conducted my 2014 investigation into suicide and self-harm among children, the only regular publicly available data from the Australia Institute of Health and Welfare and the Australian Bureau of Statistics was in relation to suicide among children 15-24, and in one large age cohort only. This combined children and adults in very different life phases and potential intervention settings and also excluded younger children. On request, I was able however to source more nuanced age sensitive data specifically for the investigation from the National Coronial Information System over a 5 year period (4-9,10-11,12-13,14-15, 16-17) and from the ABS (5-14, 15-17). As well, I was required to pay for a special report on self-harm sourced from the hospital system via AIHW. Since then, in line with my recommendation, AIHW has produced regular suicide data for under 18s, it remains available in one large age cohort of 5-17 only.

Regular information broken down into useful age cohorts is necessary to mount appropriate policy and program interventions for children of different ages active in different settings. Further demographic and other characteristics breakdowns are also limited, for example, in relation to socio-economic status, LGBTI children, children with a disability and children from culturally and linguistically diverse backgrounds.

As the draft report sets out, while there are some measures of the state of child mental health, these are either confined to certain age groups, geographic areas/states or territories, or nested one-off efforts. It is important that there are regular, comprehensive and robust national surveys of children and their experiences of mental health with capacity for international comparisons and trend tracking. Opportunities to augment Australia's efforts in this area are available through participation in:

- The Global School-based student health survey (GSHS): a collaborative surveillance project designed to help countries measure and assess the behavioural risk factors and protective factor in ten key areas (including

mental health) among young people aged 13-17 https://www.who.int/ncds/surveillance/gshs/en/; and

- The World Health Organisation's international study of *Health Behaviour in School-Aged Children* (HBSC). The HBSC collects data every four years on 11, 13 and 15-year-olds' health and well-being, social environments and health behaviours: http://www.hbsc.org/

Recommendations relating to the AIHW's work on indicators of child social and emotional wellbeing is strongly supported, this should be done in consultation with child welfare experts and children themselves.

Screening

The recommendations for perinatal mental health screening and expanding the existing early childhood health checks are strongly supported. However, similar checks are required at other points in childhood where risk factors can emerge, such as during the middle years.

Support for education providers

One standard evidenced based education program to suit different ages should be required to be rolled out in all schools and preschool settings. *Be You*, in particular, requires proper evaluation to determine if it is being implemented effectively, changes practice and meets the needs of educators. Other types of programs that focus on creating healthy, inclusive whole of school communities have been found to be particularly effective.

Parallel programs directed at students and parents may also be needed (such as Cool Kids: https://www.mq.edu.au/about/campus-services-and-facilities/hospital-and-clinics/centre-for-emotional-health-clinic/programs-for-children-and-teenagers/expandable-information/cool-kids-program).

Any national framework to support educators with child mental health should be designed to complement and connect with other programs such as Respectful Relationships.

Other vulnerable groups of children

The draft report identifies particular cohorts of children and young people that are at risk of experiencing poor mental health, such as Aboriginal and Torres Strait

Islander children, children in the care system and those who live in regional and remote areas. The risk of poor mental health for these groups is well-documented and affirmed through the investigations I have undertaken. However, there are other groups of children and young people that also face heightened risk of developing mental health issues and for whom interventions should be prioritised.

Young parents and their children

In 2017, I investigated the needs of young parents and their children.

Young people who become parents at an early age are likely to experience significant obstacles and disadvantage in their lives. Higher rates of teenage pregnancy are associated with family histories of teenage pregnancy, unstable housing arrangements, socio-economic disadvantage and sexual abuse in childhood.

The challenging personal circumstances of many young parents are further compounded by the social, financial, medical, education and employment difficulties of raising a child. Young parents frequently face negative consequences such as poverty and long-term welfare dependency,[41] poor emotional health and wellbeing,[42] and inability to complete study or gain secure employment.[43]

Becoming pregnant at a young age can have a negative impact on a young person's mental health because of the social stigma and prejudice associated with teenage motherhood. Many young parents experience feelings of shame and stigmatisation in their interactions with schools, family members, friends, their community, agencies, the rental market and health care professionals. Negative community attitudes towards teenage motherhood can consequently act as a substantial impediment to young parents accessing services.

A history of childhood physical and sexual abuse is considered a key risk factor leading to adolescent pregnancy and young parenthood. One study suggested that 20% of pregnant teenagers had experienced family or partner violence prior to the age of 16.[44] Partner violence is considered commonplace for teenagers and for women during young adulthood, with some research indicating that young mothers could be at a higher risk.

Young mothers with a history of childhood abuse or trauma can develop distrust of services, resulting in a reluctance to leave their children with strangers. This can be exacerbated by mental health issues that may have been brought on or amplified by the birth of their child and can also lead to greater social isolation and increased depression, anxiety and low self-esteem.[45]

Children of young parents are also at greater risk of experiencing poorer life outcomes. According to the Australian Institute of Health and Welfare (AIHW),

children born to teenage mothers are 'at greater risk of low birthweight and increased morbidity during their first year of life, tend to develop more behaviour problems than children of older mothers and are more likely to be born into, and continue to live in, social and economic disadvantage'.[46] Children of vulnerable young parents are often at risk of being removed into the care and protection system, and are also more likely to become young parents themselves.[47][6]

Further information about my investigation into young parents and their children, including links to my recommendations, is available here: https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2017

Children in the juvenile justice system

Children with disability are overrepresented in the youth justice system, particularly children with intellectual disabilities or psychosocial disabilities.[48] In one survey of the NSW youth justice system in 2015, 83.3% of children surveyed met the criteria for at least one psychological disorder—six times the prevalence rate for children in the general population.[49]

Children with Fetal Alcohol Spectrum Disorder (FASD) are particularly prevalent in the youth justice system.[50] One study in Western Australia found that 89% of children in detention between May 2015 and December 2016 had at least one domain of severe neurodevelopmental impairment and 36% were diagnosed with FASD.[51] The majority of those with FASD had not been previously identified, highlighting a need for improved diagnosis.[52]

Disability advocacy organisations have argued that the high incarceration rate is due to the failures in mental health, child protection, housing, disability and community service systems to provide appropriate assessment and supports for children with disability.[53] The UN Committee on the Rights of Persons with Disabilities, in its Concluding Observations on Australia in September 2019, has expressed concern about the overrepresentation of convicted young persons with disabilities in the youth justice system, especially male youth from Indigenous communities.[54]

In some jurisdictions, declarations of unfitness to stand trial may lead to the indefinite detention of unconvicted people with disability, including children with disability.[55] Under Western Australia's *Criminal Law (Mentally Impaired Accused) Act 1996*, a person can be indefinitely detained without trial if found unfit to stand trial.[56] A person can spend a longer time in detention than if they pleaded guilty and were sentenced to imprisonment for the offence. There are no special procedures for children.[57]

Children with FASD are at particular risk of being held in indefinite detention.[58] A recent Australian study of FASD in Western Australia's juvenile detention population reported increasing concern regarding the forensic implications of FASD in Australia:

> …as the neuropsychological sequelae can affect all aspects of the legal proceedings, including the person understanding the expectations and providing credible evidence in forensic interviews, fitness to plead, capacity to stand trial and the process of sentencing.[59]

Further information about my investigation into children and young people in detention, including links to my recommendations, is available here: https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2016

Children who experience family and domestic violence

A key observation from my 2014 research was that adverse family experiences, including poverty, domestic violence, parent with alcohol or drug dependency, parent in gaol, parent with a mental illness, person known to the child who died due to intentional self-harm were key distal factors for child suicides, along with:

- mental health problems
- alcohol and drug abuse
- child abuse, including physical and sexual abuse
- adverse family experiences, including poverty, domestic violence, parent with alcohol or drug dependency, parent in gaol, parent with a mental illness, person known to the child who died due to intentional self-harm
- previous suicide attempt(s)
- communicated suicidal intent
- intentional self-harm, with or without suicidal intent.[60]

In 2015, I subsequently looked directly at the impact on domestic violence on children.

I found that while children's exposure to domestic violence (as witness, bystander and victim) is extraordinarily high and has far-reaching consequences, relatively little attention is paid to preventing children's exposure or providing therapeutic support to recover from that exposure. As a result, many children develop mental health issues, exhibit risky behaviours, are anxious and withdrawn, or self-harm. Any national approach to mental health needs to take account of the serious impact of family and domestic violence on the mental health of children.

Further information about my investigation into suicide and self-harm, including links to my recommendations, is available here: https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014

Children themselves identify mental health as a priority issue

In addition to the issues raised above, I would like to conclude by emphasising that mental health and wellbeing are also of crucial importance to children and young people themselves. In consultations that I have conducted with children and young people during my term as National Children's Commissioner (2013 to the present), they have consistently identified mental health, suicide and self-harm as priority issues to address in order to improve their overall health and wellbeing.

Further, in 2018, Mission Australia's *Youth Survey Report* of more than 28,000 young people aged 15–19, mental health was identified as the main concern for young people in all states and territories. The rate of young people who identified mental health as a key national issue doubled from 21% in 2016 to 43% in 2018.[61]

I appreciate the opportunity to comment on the current draft report and look forward to reading the final version when it becomes available.

Yours sincerely,

Megan Mitchell
National Children's Commissioner

[1] Australian Bureau of Statistics, 3303.0 – Causes of Death, Australia, 2012 (2014), Table 1.3, Line 40. <http://www.abs.gov.au/>
[2] Australian Human Rights Commission, *Children's Rights Report 2014* (2014) 124 <https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014>
[3] Australian Human Rights Commission, *Children's Rights Report 2014* (2014) 150 <https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014>
[4] M Nock, *The Oxford Handbook of Suicide and Self-Injury* (2014), p 502.
[5] R O'Connor, S Platt and J Gordon, *International Handbook of Suicide Prevention: Research, Policy and Practice* (2011), p 10.
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[7] Australian Human Rights Commission, *Children's Rights Report 2014* (2014) 156 <https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014>
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[9] M Nock, 'Future directions for the study of suicide and self-injury' (2012) 41(2) *Journal of Clinical Child and Adolescent Psychology* 255, p 257
[10] K Bentley, M Nock and D Barlow, 'The Four-Function Model of Nonsuicidal Self-injury: Key Directions for Future Research' (2014) *Clinical Psychological Science*, p 7.
[11] M Nock, 'Future directions for the study of suicide and self-injury' (2012) 41(2) *Journal of Clinical Child and Adolescent Psychology* 255, p 257.
[12] Australian Government National Health and Medical Research Council, *National Statement on Ethical Conduct in Human Research* (2014).
[13] C Haw, K Hawton, C Niedzwiedz, and S Platt, 'Suicide Clusters: A Review of Risk Factors and Mechanisms' (2013) 43(1) *Suicide and Life-Threatening Behavior*, p 97.
[14] C Haw, K Hawton, C Niedzwiedz, and S Platt, 'Suicide Clusters: A Review of Risk Factors and Mechanisms' (2013) 43(1) *Suicide and Life-Threatening Behavior*, p 97.
[15] C Haw, K Hawton, C Niedzwiedz, and S Platt, 'Suicide Clusters: A Review of Risk Factors and Mechanisms' (2013) 43(1) *Suicide and Life-Threatening Behavior*, p 105.
[16] C Haw, K Hawton, C Niedzwiedz, and S Platt, 'Suicide Clusters: A Review of Risk Factors and Mechanisms' (2013) 43(1) *Suicide and Life-Threatening Behavior*, p 105.
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[18] Australian Healthcare Associates, *Evaluation of Suicide Prevention Activities, Final Report* (2014), p 10.
[19] Orygen Youth Health Research Centre, Submission 82, p 11.
[20] Menzies School of Health Research, Submission 102, p 39.
[21] S Jarvi, B Jackson, L Swenson and H Crawford, 'The Impact of Social Contagion on Non-Suicidal Self-Injury: A Review of the Literature' (2013) 17(1) *Archives of Suicide Research*, p 12.
[22] Australian Human Rights Commission, *Children's Rights Report 2014* (2014) 158 <https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2014>
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