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RACP submission to National Children's Commissioner report: Australia's progress in implementing the United Nations Convention on the Rights of Children

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Thank you for the opportunity to provide feedback to the National Children's Commissioner report: Australia's progress in implementing the United Nations Convention on the Rights of Children (UNCROC).

The Royal Australasian College of Physicians (RACP), represents over 17,000 fellows and 7,500 trainees across over 30 specialties in Australia and New Zealand. Our membership includes 5,100 paediatric fellows and trainees, who routinely work with newborns, infants, young children and their families. Our Paediatric and Child Health Division is currently leading policy development in a number of relevant areas, including inequities in child health, early childhood and Indigenous child health.

Australia has experienced 20 years of sustained economic growth and is one of the wealthiest countries in the world with responsibility to all members of society, particularly children. This includes responsibility to ensure the best start in life and strong efforts to promote the health and wellbeing of the most disadvantaged. All children should have the opportunity to lead a life free of preventable mortality and morbidity. The existence of child health inequities in Australia means that not all children get a fair chance of healthy development or fair access to healthcare.

For this submission, we have consulted widely across the College and have received feedback on the cluster of rights from individual members as well as our key policy committees and College bodies. The RACP has not responded to every article, but focuses on highlighting insufficient progress implementing the UNCROC, especially in the areas of:

- Aboriginal and Torres Strait Islander children;
- Refugee children seeking asylum in Australia;
- Children in out of home care;
- Children living with disability;
- Children in the juvenile justice system;
- The need to raise the age of criminal responsibility from 10 to 14 years old; and
- Child mental health services, especially regarding the alarmingly high rates of youth suicide in Australia.

Clusters of rights

General measures of implementation (art. 4, 42, 44(6))

The RACP has no specific comments to make.

Definition of the child (art.1)

Age of Majority – Criminal responsibility

All Australian states and territories currently have laws that allow children as young as ten years to be charged, brought before the courts, sentenced and imprisoned. In all Australian jurisdictions there is a rebuttable presumption of *doli incapax* for children aged 10 to 14 years old, which presumes that the child is incapable of committing a crime because they did not know or did not have capacity to know that their act or omission was criminally wrong.

Through the *doli incapax* presumption, the current law recognises that children below 14 years are in need of protection from the criminal justice system. However, this old, common law presumption is failing to safeguard children. This is because of inconsistent application, inability to access expert evidence and judicial discretion and because it does not reflect contemporary medical knowledge of childhood brain development, social science, long term health effects, or human rights law.

The RACP strongly opposes such a low age of criminal responsibility and has advocated previously to raise the age of criminal responsibility from 10 to 14 years of age supporting the Human Rights Law Commission (HRLC) advocacy work.

The criminalisation of young children is a nationwide problem. There were about 5,500 young people (aged 10 and older) under youth justice supervision in Australia on an average day in 2015–16, due to their involvement, or alleged involvement, in crime. This number has decreased by 21% over the 5 years to 2015–16. Around 4 in 5 (82%) young people under supervision on an average day were male. Most (84%) young people were supervised in the community and the remainder were in detention. Indigenous young people continued to be over-represented in the youth justice system: young Indigenous people were 17 times as likely as non-Indigenous young people to be under supervision on an average day.[1]

Evidence shows that early contact with the criminal justice system significantly increases the chances of life-long involvement with the justice system. The Royal Commission into the Protection and Detention of Children in the Northern Territory[2] (the Royal Commission) has identified that the vast majority of children who are dealt with outside of the formal system by community based alternatives, in particular diversion, do not reoffend. They are provided with an opportunity to flourish and grow into adulthood in an environment which promotes their health, education and physical and emotional development.

The current legal minimum age of criminal responsibility contrasts with medical evidence that affirms children aged 10 to 14 years lack emotional, mental and intellectual maturity. As the Royal Commission recognised, advances in neurobiological research are providing greater understanding of how the brain develops over time. Contemporary research shows that children's brains are still developing throughout these formative years where they have limited capacity for reflection before action. Children in grades four, five and six are not at a cognitive level of development where they are able to fully appreciate the criminal nature of their actions or the life-long consequences of being labelled a criminal.

The RACP's position paper *The Health and Wellbeing of Incarcerated Adolescents*[3] highlights that incarcerated adolescents are more likely to experience poorer health and life outcomes and disproportionately high levels of disadvantage over that of the general population. It is increasingly recognised that their health needs are greater than adolescents in non-custodial settings.

General principles

- non-discrimination (art. 2)
- best interest of the child (art. 3)

Refugee and asylum seeker children in immigration detention

As of February 28th, 2018, 30 children are currently being held in detention in Nauru. The average period of detention was 426 days, with 72.2% detained for a period greater than 548 days, and 37.8% detained for over 730 days[4].

Currently children seeking asylum in Australia are detained on Nauru by the Australian government without their consent because of the actions of their parents. This appears to contravene Article 2. Children seeking asylum who arrive as "illegal maritime arrivals" are detained in off-shore detention. The aim of this policy is to act as a deterrent to others. This is clearly against the bests interests of the child, and appears to contravene Article 3.

Civil rights and freedoms

- access to information from a diversity of sources and protection from material harmful to his or her well-being (art. 17)

Protecting children from harmful content and activity online

The sheer ubiquity of phone, tablet and computer access to the internet and pornography makes unintentional or intentional exposure to pornography increasingly likely for Australian children and young people.

Children and young people are using the internet in enormous numbers. According to the Australian Bureau of Statistics, in 2009, 96 per cent of 12–14-year-olds in Australia went online, with 60 per cent doing so via a mobile device.[5] Children and young people can access pornographic material over the internet intentionally, or by accident. Different Australian studies with different methodologies have returned varied results, but it is

consistently demonstrated that a high proportion of young people are viewing pornography on the internet. One study has found that 28 per cent of 9 to 16-year-olds have seen sexual material online, though of particular concern is the indications that the percentage is 73 per cent for 15 to 16-year-olds.[6] Other research found that among 13 to 16-year-olds, 93 per cent of males and 62 per cent of females had seen pornography online.[7] Generally, young males are more likely to access pornography (either intentionally or unintentionally) then young females.[8]

Studies here and overseas, particularly in the United States, have shown that the likelihood of unintentional exposure to internet pornography increased generally for all children and young people from 1999 to 2005, in addition to increasing with age.[9,10] Though inherently difficult to quantify, one researcher has estimated that 12 per cent of all publicly available websites are pornographic, and around a quarter of search engine requests relate to pornography.[11]

Whilst policing and regulation are important, often children and young people are not deterred by rules or laws.[12] Some existing resources (both Australian and foreign) provide advice to parents on how to manage specific risks - such as young children's internet access, or sexting – and schools should make reasonable efforts to provide such resources to parents. Whilst restricting exposure to pornography where possible is important, a reliance on this approach alone would fail to recognise the ready availability and high acceptance of pornography among young people.[13]

The RACP has previously called for improved sexual health education for children and young people,[14] as education for both children and parents is an important tool to combat emerging threats to the mental and physical health of children and young people. Evidence suggests that providing accurate and age-appropriate information on sexual health to young people does not lead to an earlier engagement in sexual activity.[15] Therefore, RACP recommends that state and territory education departments should consider how schools can manage risks to children such as inaccurate sex education via pornography, and sexting.

Violence against children

- abuse and neglect, including physical and psychological recovery and social reintegration (arts. 19 and 39)

Child protection

The health and welfare of children must be the primary consideration in all child protection measures. Childhood and adolescence are critical phases in human development and child protection measures must ensure that vulnerable young people are given every opportunity to establish healthy behaviours for life. The RACP supports early intervention child protection models that recognise and respond to children at risk of harm. These models should consider the current medico-legal approach of mandatory reporting and how to mitigate any unintended consequences of this system.

The RACP's position statement *Protecting Children is Everybody's Business: Paediatricians Responding to the Challenge of Child Protection*[16] calls for greater support for a public health model of child protection. This model incorporates primary and secondary interventions, in addition to tertiary responses for those children who have or may have suffered abuse.

Refugee and asylum seeker children in immigration detention

The Forgotten Children report[17] and the Moss review report[18] show that children were subjected to sexual abuse on Nauru. Our Fellows have reported at the time of writing that prolonged detention has resulted in children on Nauru becoming suicidal, and that three have already been transferred to Australia already in 2018. They have reported that in each occasion the Australian Government rejected medical advice and refused transfer until the case was about to come to court, at which point the Government transferred the child. This suggests the Government's intention is to obstruct transfer but does not want the situation aired in court. This appears to contravene Article 19.

Physical and psychological recovery for the Stolen Generation

Many Aboriginal and Torres Strait Islander peoples see the separation of children "from land and kin" as a form of abuse in itself. Disruption of cultural ties and identity can result in life-long harm and trauma as recognised in "the stolen generation".[19]

The right to physical and psychological recovery was denied for the Stolen Generation. Whilst they are now adults, their children and grandchildren inherit the transgenerational transmission of this trauma. For the children of the stolen generation recognition of this trauma must be considered when delivering health care services. The RACP recommends the establishment of culturally appropriate health and social services which consider language(s), beliefs, gender and kinship systems, deliver care in a manner which respects these factors, is free of discrimination and takes account of the need for trauma-informed care. be included in formulating strategies to overcome any impediments to their social and emotional development.[20]

- sexual exploitation and sexual abuse (art. 34)

The RACP is concerned that the Forgotten Children report and the Moss report showed that children have been subjected to sexual abuse on Nauru. This appears to contravene Article 34.

Family environment and alternative care

- family environment and parental guidance in a manner consistent with the evolving capacities of the child (art. 5)

Physical punishment (applies also to art. 19)
A safe environment for a child to live and grow up in must include an environment free from family violence including physical punishment of children. There is well established evidence that using physical punishment (such as hitting or smacking a child) to discipline children can have adverse consequences in the long term for the child's health, particularly their behaviour and emotional wellbeing.[21,22,23,24,25]

In Australia, it remains lawful for parents in all jurisdictions to use physical punishment for children. In many jurisdictions this right is stated explicitly, often using the term "reasonable" to describe the level of force or chastisement that is permitted. While, under the civil law a child (like any other person) can sue any person who physically harms them, a parent would have a legal defence if they claim they were using reasonable force for purposes of correction under the current law. [26] In line with its consensus policy statement[1] on physical punishment, the RACP recommends that the legal defences in Australia for the use of corporal punishment should be amended to state that all forms of corporal punishment are unlawful so that the law protects children from assault to the same extent that it does adults.[27]

- separation from parents (art. 9)

Children detained on Nauru against their will can be separated from their parents who are residing in Australia When a child or parent is brought to Australia for medical purposes they may be separated from the remainder of the family who remain on Nauru. This appears to contravene Article 9.

- parents' common responsibilities, assistance to parents and the provision of childcare services (art. 18)

Paid parental leave
The Australian Government provides paid parental leave for 18 weeks for the carer of a newborn or newly adopted child as well as 2 weeks paid *Dad and Partner Pay*.[28] The RACP recommends that governmental paid parental leave policies in Australia should provide support for up to 6 months of paid parental leave.

Several studies have found positive associations between paid parental leave and better maternal and child health, with outcomes including: higher rates of breast-feeding[29] and use of preventative health care;[30] lower rates of maternal depression,[31] infant mortality[32] and low birth-weight babies.[33]

International outcomes following institution of paid parental leave suggest that paid parental leave may be an effective intervention for reducing inequities in health and child achievement. For example, in the decades following Norway's conversion from 12 weeks of unpaid leave to 18 weeks of paid job-protected leave, a range of benefits in child achievement were observed. Improvements were seen across the population,

[1] The RACP consensus policy statement on physical punishment is supported by the majority of RACP's paediatric members.

however, importantly, the benefits were most marked (approximately doubled) in children of disadvantaged mothers.[34]

Following extensive submissions and literature reviews in 2008/09, the Australian Productivity Commission report on Paid Parental Leave[35] found comprehensive evidence in support of paid parental and maternity leave on the grounds of child and maternal welfare. The report concluded that there was compelling evidence that six months exclusive parental care fosters improved developmental outcomes of children, with evidence of problematic outcomes strongest where non-parental care is initiated early, child care hours are very long and care is of low quality. Further, the Productivity Commission reported that there is evidence that paternity leave has emotional benefits for fathers, positively affects children's emotional and educational achievement and facilitates support for the mother.

Child care and support for working caregivers

In principal, the RACP welcomes the New Child Care Package[36] which will be introduced by the Australian Government from July 2018 replacing the existing Child Care Benefit and Child Care Rebate, but is concerned about reports[37] that some low income and single parent families might receive less or no assistance under the new package compared to the old system.

- children deprived of family environment (art. 20)

Children in out of home care (OOHC)
The most recent statistics from AIHW (2017a) show that, as of 30 June 2016, there were 46,500 Australian children living in out-of-home care. This has increased from 7.4/1,000 children at 30 June 2011 to 8.6/1,000 children at 30 June 2016.

These numbers have particularly increased for Aboriginal children. As of 30 June 2016, there were 16,846 Aboriginal and Torres Strait Islander children in out-of-home care in Australia—a placement rate of 56.6 per 1,000 children. In contrast, the rate for non-Indigenous children was 5.8 per 1,000. In other words, the national rate of Aboriginal and Torres Strait Islander children in out-of-home care was almost 10 times the rate for non-Indigenous children.[38]

Children in out of home care (OOHC) have poorer health, developmental and wellbeing outcomes than their peers.[39] This is largely due to the adverse effect of neglect and abuse on neurodevelopment[40] and metabolic pathways. There is a growing body of literature that illustrates the life-long impact of Adverse Childhood Experiences on chronic disease, health, development and wellbeing.[41]

The Australian National Clinical Assessment Framework for Children and Young People in OOHC[42] aimed to address these poorer health outcomes by proposing a tiered approach to age-appropriate assessments. It covers the key domains of physical health, developmental, psychosocial and mental health, including core elements of Preliminary Health Check, Comprehensive Health and Developmental Assessment and the Development of a Health Management Plan.

A recent review of the health needs and health care of children in OOHC in Australia in 2016 (with a focus on Victoria)[43] raises concerns about the lack of adequate regulatory and legislative changes to "effectively assign responsibility and assure accountability" for the monitoring of health needs and receipt of health care for these children. It also raises issues around poor collection and analysis of health needs data to assess longitudinal health outcomes, and to properly inform policy. It criticises the dependency on community support organisations to provide health care coordination for these children, instead of through appropriately resourced health services.

Paediatricians often lead the health care for children in OOHC. In line with the above mentioned Australian National Clinical Assessment Framework[44], the RACP supports[45] a synergistic approach in advocating for proactive, routine, multi-disciplinary health screening, the developmental of health management plans, enhanced access to health and mental health care for OOHC children, and enhanced communication tools including transferable health records and access to relevant family history. However, the RACP is concerned about the effectiveness of the implementation of the Framework, and the absence of specific Australian Government initiatives (such as the provision of new Medicare item numbers or the funding of specific multi - disciplinary teams for example).

Disability, basic health and welfare

- measures taken to ensure dignity, self-reliance and active participation in the community for children with disabilities (art. 23)

Children living with disability

Children with disability should have the opportunity to access specialist services and therapy in a timely manner to ensure each child reaches their developmental potential. However, under the current National Disability Insurance Scheme (NDIS) framework, we understand that children are waiting up to 12 months to receive funded intervention, whilst also being excluded from access to public therapy services based on their diagnosis. In addition, information on interventions that are based on best available evidence is not fully transparent for families when they select and access therapy programs. The significant delays for children with disability in accessing services and intervention programs appears to be in contravention of Article 23 as well as Article 24.

Children diagnosed with Autism Spectrum Disorder (ASD) are required by the NDIS to state levels of ASD severity, which is then utilised to determine eligibility for services. This is contrary to the Diagnostic and Statistical Manual of Mental Disorders (5th edition, DSM-5) which states "descriptive severity categories should not be used to determine eligibility for and provision of services"[46]. Another major concern is the prioritisation of service eligibility requirements, over and above a consideration of the child's best interests, which appears to be in contravention of this article as well as article 3 of the UNCROC.

Children with disability with behavioural/emotional issues are sometimes suspended from educational services, which continues restrict their access to a learning curriculum, limiting their ability to achieve their full potential.

The long-term impact on families and carers providing support for children with disabilities is not fully recognised, preventing entire families (including siblings) from participating fully in the community. For example, parents' ability to work whilst supporting their child with a disability is reduced, and financial recompense from the Government is limited, with means-testing determining eligibility for child care allowance and payments. This limited ability for families caring for children with disability to participate in the community appears to be in contravention of Article 23.

Australian children and young people with a disability are three times more likely to experience violence and physical abuse than their non-disabled counterparts[47], and three to four times more likely to be the victim of sexual abuse.[48]

- survival and development (art. 6(2))

Addressing inequitable outcomes in child health (this section also relates to art. 24)

The RACP is concerned that children in rural areas face worse health outcomes. We know that health care inequities occur where there is unequal access to services (including their utilisation, quality and distribution) that are dependent on demographic variables, such as ethnicity and socioeconomic status rather than need.

Below are data tables on the age standardised rates for death per 100,000, age standardised rate of potentially avoidable deaths and the leading causes of death by remoteness between 2009-11 showing increases based on the remoteness of a child's home in Australia. The RACP recommends that all health policymakers in Australia should recognise equity of health outcomes as a primary goal, with specific mention of rurality to ultimately improve health outcomes in child health.

Table 5: Age standardised death rate (per 100,000), 0-14, 2009-2011

	males	females	persons
Major cities (MC)	38.8	29.4	34.2
Inner regional (IR)	44.1	35.1	39.7
Outer regional (OR)	53.2	43.5	48.5
Remote (R)	59.2	46	52.8
Very remote (VR)	108.3	95.4	102

Source: http://www.aihw.gov.au/publication-detail/?id=60129548021&tab=3

Table 6: Age standardised rate of potentially avoidable deaths, 0-14 years, 2009-2011

	Potentially preventable deaths	Potentially treatable deaths	Potentially avoidable deaths
MC	2.9	16.3	19.2
IR	6	16.7	22.7
OR	7.5	20.4	27.9
R	9	18.8	27.8
VR	20.4	40.9	61.3

Source: http://www.aihw.gov.au/publication-detail/?id=60129548021&tab=3

Table 7: Leading causes of death, by remoteness, 0-14 years, 2009-2011

	MC	IR	OR	R	VR
Certain conditions originating in the perinatal period	20.5	20.1	23.5	22.9	39.8
SIDS	1.5	2.4	3.1	3.7	5.1
ill defined causes	1	1.2	2.3	5.7	8.4
Land transport accidents	0.9	2.4	3.7	6.6	9.2
Brain cancer	0.7	0.9	0.9	n.p.	n.p.
Selected metabolic disorders	0.7	0.5	0.6	n.p.	n.p.
Accidental drowning	0.6	1.2	1.8	1.2	4.5
Accidental threat to breathing	0.3	0.4	0.4	1.9	1.8
Suicide	n.p.	n.p.	n.p.	n.p.	3.2
Cerebral Palsey and others	0.4	0.6	1.4	n.p.	2.8
Influenza and pneumonia	0.3	0.5	0.8	n.p.	4.5
meningitis	0.2	n.p.	n.p.	n.p.	3.6
exposure to fire and smoke	n.p.	0.9	0.4	n.p.	n.p.
Leukaemia	0.4	0.4	0.5	n.p.	n.p.

Source: http://www.aihw.gov.au/publication-detail/?id=60129548021&tab=3

Children living in disadvantage are at increased risk for chronic health problems, including cerebral palsy, learning difficulties, developmental delay, intellectual disability mental health problems and school achievement. Research from “Growing up in Australia”, the Longitudinal Study of Australia’s Children (LSAC), has demonstrated that social disadvantage is associated with poorer outcomes across most measures of physical and developmental health.[49]

These inequities start early. The Australian Early Development Census (AEDC), a triennial population census of early childhood development shows that by the time Australian children start school, there are clear inequities. The 2012 AEDC results demonstrate that 17.4 per cent of children who lived in the most disadvantaged areas in Australia were developmentally vulnerable in two or more domains of early childhood development including physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. This compared to the 6.5 per cent of children living in the most advantaged areas. Children who are developmentally vulnerable in two or more domains are often not equipped with the developmental skills they needed to flourish at school.[50] Aboriginal and Torres Strait Islander children were almost twice as likely to be developmentally vulnerable than other Australian children, and to require special assistance in making a successful transition into school learning. Aboriginal and Torres Strait Islander children in remote areas are particularly disadvantaged, and in 2012, 20.3 per cent of Aboriginal and Torres Strait Islander year 5 students in very remote areas achieved national minimum standards in reading, compared with 76 per cent in metropolitan areas.

The presence of child health inequities results in a life with less chance to reach one's potential, and means that certain groups in the population miss out on the opportunities that their societies offer. By tackling health inequities, societies achieve better health overall and the social gradient flattens with a "spill over" effect on non-health outcomes such as social, educational and workforce inclusion.

In its recently launched position statement on inequities in child health, the RACP strongly recommends that Australian governments measure, report on and address child health inequities throughout Australia. A coordinated policy approach to reduce child health inequity is critical.[51]

Childhood obesity rates

Since 1980, obesity rates have nearly doubled in Australia. In Australia in 1980, 3.5 per cent of children had obesity, increasing to 8 per cent in 2015.[52] In 2014–15, about 1 in 4 (26%) Australian children and adolescents aged 2–17 were overweight or obese. That's around 1.2 million children and adolescents.[53] About 1 in 6 (18%) children and adolescents aged 2–17 were overweight but not obese, while about 1 in 13 (8%) were obese. One in 5 (20%) boys aged 2–17 were overweight but not obese, while 7% were obese. Among girls of the same age, around 1 in 6 (16%) were overweight but not obese and 9% were obese.

The latest available data from the Australian Bureau of Statistics shows that obesity rates for Aboriginal and Torres Strait Islander males and females were significantly higher than the comparable rates for non-Indigenous people. For example, in 2012–13, nearly 1 in 3 (30%) Aboriginal and Torres Strait Islander Australian children and adolescents aged 2–14 were overweight or obese. One in 5 (20%) Indigenous children and adolescents aged 2–14 were overweight but not obese, while 1 in 10 (10%) were obese. At age 15–17, 35% of Aboriginal and Torres Strait Islander Australian adolescents were overweight or obese. About 1 in 5 (21%) Indigenous adolescents aged 15–17 were overweight but not obese, while about 1 in 7 (14%) were obese. Among Indigenous boys, 18% were overweight but not obese and 10% were obese at age 2–14, while 21% were overweight but not obese and 17% were obese at age 15–17. Among Indigenous girls, 21% were overweight but not obese and 11% were obese at both age 2–14 and age 15–17.[54]

High body mass index is now the leading preventable cause of health loss. The increase in childhood obesity is particularly concerning: children with obesity are more likely to be obese as adults and may experience comorbid symptoms earlier in life. Obesity, and in particular morbid obesity, is a chronic disease with multiple health consequences for people Comorbidities associated with obesity can lead to reductions in people's quality of life, and can ultimately be life-limiting. Musculoskeletal conditions, pain and osteoarthritis can make mobility and physical activity difficult, and obesity increases the risks of many non-communicable diseases such as type 2 diabetes mellitus, cardiovascular disease, obstructive sleep apnoea and many types of cancer.

Despite the increasing rates of obesity in our societies and a greater strength of evidence for interventions, successive governments in Australia have yet to implement comprehensive actions across society to reduce obesogenic environments and their underlying societal determinants. While some steps have been taken, there is a lack of urgency in implementing World Health Organization (WHO) recommended policies and actions, including

- The 2010 Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children[55]
- Implementation of a tax on sugar-sweetened beverages[56]
- Healthy food service policies implemented in publicly-funded settings, especially early childhood centres, schools and government departments[57]

- health and health services, in particular primary health care (art. 24)

Birth weight and immunisation rates

In 2015, 6.5 per cent of babies were underweight at birth, with an infant mortality rate of 3.1 per 1,000 live births in 2016. The percentage of fully immunised children at age 2 has slightly fallen from 92.7 per cent in 2008 to 90.5 per cent in December 2017.[58]

Children's mental health status

Child and adolescent mental health disorders in Australia are highly prevalent, and associated with significant short- and long-term morbidity. At any one point in time, 14 per cent (560,000) of 4-17 year olds in Australia are experiencing mental health disorders.[59] The onset of disorders in childhood is now known to have adverse effects across the lifespan[60, 61] with 50 per cent of all mental disorders beginning before the age of 14 years.[62]

According to ARACY,[63] in 2014-15, 15.4 per cent of Australians aged 18-24 years suffered high or very high psychological distress, up from 11.8 per cent in 2011.

The RACP is very concerned about the rising rates of suicide amongst 15-24 year olds, increasing from 10.3 (per 100,000 population) in 2007 to 12.7 in 2016. Aboriginal and Torres Strait Islander youth were more than three times more likely to take their own lives at a rate of 39.2 (per 100,000 population) in 2016, up from 33.0 in 2007.[64]

As mentioned above, the RACP is concerned about the fact that children with disabilities are excluded from access to mental health services within the public health system. This exclusion from mental health services as a matter of ineligibility based on disability diagnoses is discriminatory, and appears to be in contravention of Article 24.

While the RACP acknowledges the priority area on suicide prevention in the 5th National Mental Health Plan, we are concerned about the significant inequity and a lack of resources and funding for the provision of mental health services, particularly for paediatric, adolescent and Aboriginal and Torres Strait Islander patients in rural and remote areas in Australia.

The financial costs alone of childhood mental disorders for education, social services, justice, and also for individual families, are very high.[65,66] Early intervention and prevention of mental health problems in all Australians including in children and adolescents and its implementation must be a priority for Australian governments.

Current state of health of Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children in Australia experience higher burden of disease and have poorer health outcomes than their non-Indigenous peers. The reasons for this disparity are multiple, and complex. The impact in terms of increased morbidity and mortality is seen during childhood, and in adulthood where the long-term sequelae of childhood illness can result in chronic diseases and early death.

Antenatal factors play a very important role in the health of children. Whilst the majority of Aboriginal and Torres Strait Islander mothers in Australia access antenatal care, this tends to occur less often and later in pregnancy, compared to other mothers. Aboriginal and Torres Strait Islander mothers are more likely to smoke tobacco, drink alcohol and/or use illicit drugs during pregnancy, compared to non-Indigenous mothers.[67] Approximately 11% of babies of Aboriginal and Torres Strait Islander mothers are low birth weight, 2.4 times the rate for babies of non-Indigenous mothers.[68] Low birth weight is associated with increased risk of death and neurodevelopmental disability in the first year of life, and can have life-long impact on morbidity.

Infant mortality has consistently reduced for Aboriginal and Torres Strait Islander infant, with important narrowing of the gap with non-Indigenous infants, although the rate (7.0 per 1,000 live births) remains almost twice the rate for non-Indigenous infants. In the Northern Territory, the Indigenous infant mortality rate is 12.7 per 1,000 live births.[69]

Under-5 mortality trends reflect infant mortality trends in both Indigenous and non-Indigenous children. Aboriginal and Torres Strait Islander children aged less than 5 years are hospitalised at 1.5 time the rate of non-Indigenous children.[70] The most common reasons for hospitalisation are respiratory illnesses, perinatal complications, and infectious diseases. Mortality differences persist in to adolescence, when all-cause mortality is more than twice that of non-Indigenous adolescents. Most of deaths in Indigenous adolescents are due to intentional self-harm or road traffic injury.[71] Aboriginal and Torres Strait Islander teenagers are far more likely than non-Indigenous to be affected by sexually transmitted infections, including chlamydia, gonorrhoea and syphilis. Notification rates for gonorrhoea are 57 times higher in Indigenous compared to non-Indigenous teenagers (3,182 per 100,000 per year, compared to 55 per 100,000 per year). Notification rates are even higher in Aboriginal and Torres Strait Islander teenagers from the Northern Territory (6,600 per 100,000 per year). Notification rates provide an under-representation of the true incidence of disease, as they rely on healthcare access, diagnosis and notification.[72]

Rates of invasive bacterial infections and severe sepsis are significant higher.[73] Invasive infections with Staphylococcus aureus and group A Streptococcus are particularly common in Northern Australia.[74, 75] Non-infectious sequelae of group A Streptococcal infections disproportionately affect Aboriginal and Torres Strait Islander children by massive orders of magnitude. Post streptococcal glomerulonephritis rates are 50 times

higher in Aboriginal and Torres Strait islander people,[76] and acute rheumatic fever and rheumatic heart disease rates are more than 60 times that seen in non-Indigenous people.[77]

It is well established that Indigenous children in Australia have poorer health outcomes compared with non-Indigenous children. Indigenous babies in Australia are twice as likely to be born at low birthweight than non-Indigenous babies (12.2% vs 6.1%), a known risk factor for adverse health outcomes later in life.[78] Indigenous child mortality for children under 5, while decreasing between 1998 and 2014, still remains higher than the non-Indigenous rate.[79] Indigenous Australians have 1.5 times the rate of disability of non-Indigenous Australians. Indigenous children in Australia aged 0-4 years are hospitalised for respiratory illnesses at 1.6 times the rate of non-Indigenous children (based on data from the years 2013-2015), and this rate has significantly increased over the preceding decade.[80] Indigenous children in Australia are more at risk of developmental vulnerabilities: the Australian Early Development Census in 2015 (based on a teacher's assessment of a child's development in their first year of school, across five domains) found that 42.1% of Indigenous children were developmentally vulnerable on at least one domain compared with 22 percent of all Australian children.[81] Australian Indigenous children have almost three times the rate of middle ear disease than their non-Indigenous counterparts, and rates of hearing loss are also higher.[82, 83]

Health services for refugee and asylum seeker children in immigration detention
Asylum seeking children detained on Nauru have access only to primary care facilities and no access to specialist paediatric facilities. The facilities on Nauru are clearly not equivalent to those provided to Australian children, however remote. Arranging transfer of these children to Australia for specialist care involves a lengthy process and the involvement of the courts. This appears to directly contravene Article 24.

- social security and childcare services and facilities (arts. 26 and 18(3))

Children who are seeking asylum in Australia do not have access to the same social supports as children who are citizens. In particular, these families cannot access crisis payments from Centrelink in times of dire financial need. This appears to contravene Article 26.

- standard of living and measures, including material assistance and support programs with regard to nutrition, clothing and housing, to ensure the child's physical, mental, spiritual, moral and social development and reduce poverty and inequality (art. 27, paras. 1–3)

Children living in poverty
The RACP is concerned about the number of children living in poverty. In 2014, 17.4 per cent of children aged up to 14 were living in households earning less than half the national median household earnings, up from 17.3 in 2010. In 2014-15, 31.6 per cent of Aboriginal and Torres Strait Islander children aged up to 14 lived in households that ran out of money for basic living expenses in the previous 12 months.[84]

Standard of living for refugee and asylum seeker children in immigration detention
The RACP is concerned about reports that children held in offshore detention on Nauru are housed in tents without air conditioning or fans in very high temperatures. Showering is limited to 2 minutes a day. These conditions are not an adequate standard of living for these children. This appears to contravene Article 27.

Education, leisure and cultural activities

- right to education, including vocational training and guidance (art. 28)

Right to high quality preschool
Australia trails the OECD in pre-school attendance, ranked 35 of 40 nations in 2014. The percentage of 4-5 years olds who usually attend preschool has fallen from 85 per cent in 2011 to 83.3 per cent in 2014.

Ample research[85] demonstrates the benefits of early childhood education (ECE) for later life outcomes are long-term and far-reaching, particularly for disadvantaged children. Broader impacts of quality ECE, beyond improved school performance include higher level of employment, income and financial security, improved health outcomes and reduced crime.[86]

The Australian Government has made commitments to improving ECE attendance and developed a national commitment to universal access of ECE for all children in the year before full-time schooling in 2006. The

National Partnership agreement on Early Childhood Education (NPAECE) commits Australian state and territory governments to provide universal access to an ECE program for 15 hours per week or 600 hours a year to all Australian children in the year before school. Under the NPAECE, the Australian Government provides funding to the state and territory governments to implement this universal access initiative.[87]

However, given the fall in pre-school attendance, the RACP strongly recommends considering extending the 15 hours per week (600 hrs per year) of subsidised preschool places starting from 3 years old for all Australian children.

Special protection measures

- children outside their country of origin seeking refugee protection, unaccompanied asylum-seeking children, internally displaced children, migrant children and children affected by migration (art. 22)

Concerns have been raised about contravention of Article 22 by Australia as since the introduction of mandatory detention in 1972 and especially since offshore processing was introduced. Children who came to Australia by boat seeking refugee status (deemed “illegal maritime arrivals” by the Australian Government) are still being held in indefinite off shore detention on Nauru in conditions that are detrimental to their physical and mental health. This is done to act as a deterrent to others even though it appears to contravene Australia's international responsibilities as a signatory to this convention.

- children belonging to a minority or an indigenous group (art. 30)

With regards to Aboriginal and Torres Strait Islander children, please refer to our responses throughout this submission.

Rights and needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) children and adolescents
In 2014, 72.3 per cent of those aged 16 to 27 who identify as LGBTIQ said that they had experienced abuse because of their sexuality and/or gender identity.[88]

The RACP has advocated for the health needs of young people, including same-sex attracted and gender questioning young people. Same-sex attracted young people often face greater social and emotional challenges than those encountered by heterosexual young people. Bullying, feelings of isolation, and difficulties in rural and regional areas can be more pronounced. These challenges are reflected in higher rates of depression, anxiety and risky sexual behaviours in addition to reports of high levels of discrimination.

Gender-questioning young people often face increased risk of reduced academic performance, school change or drop-out, homelessness, physical abuse, self-harm and suicide. Difficulties experienced by same sex attracted and gender-questioning young people may lead to poorer long-term health outcomes.

These outcomes can be improved through more extensive education, both in schools and the wider community, but also for medical professionals through existing training programs. The RACP recommends that all young people should receive age and developmentally appropriate sexual health education that focuses on both sexuality and relationships and is of high quality, scientifically accurate and delivered by properly trained and supported personnel, including teachers, school nurses and other health professionals.[89] Sexuality and relationships education helps young people understand and manage the physical, social and emotional adjustments of adolescence. It helps manage changes to sexual and gender identity, fosters understanding of sexual and reproductive health and health care, and encourages skills that equip young people to manage intimate relationships through promotion of mental health issues, safety, assertive behaviour, managing risk taking in relation to drug use, and respectful relationships.[90]

Gender dysphoria
Access to best practice health care for individuals who identify as gender diverse or transgender is limited by both the medical and legal systems in Australia.

There is an urgent need for improved access to publicly funded specialist outpatient health care in both paediatric and adult settings. This is not as simple as funding infrastructure alone. Improving treatment access requires the integration of training on gender identity and transgender medicine into existing undergraduate and postgraduate medical courses, increased Pharmaceutical Benefits Scheme and Medicare funding for medical and surgical treatment options, and review of judicial processes as outlined below.

Currently, medications and surgical procedures that have therapeutic benefits for gender diverse and transgender patients are often substantially or entirely privately funded. For example, gonadotropin-releasing hormone analogues used to suppress puberty in adolescents are not funded through the Pharmaceutical Benefits Scheme and currently cost approximately $5000 per patient per year. This cost prevents care from being affordable in general practice and community settings. Similarly, Medicare item numbers do not exist for therapeutic surgical procedures which prevents surgical care being provided in public hospitals or being subsidised in private settings. Surgical treatment is in essence denied to those of low socioeconomic status.

RACP welcomes the recent decision[91] to remove the requirement for The Family Court of Australia to approve treatment using oestrogen and testosterone in people under the age of 18 years. Additional reforms we recommend need to happen in Australia to meet Australia's obligations under the UNCROC include:

- Removal of the need for genital sex-affirmation surgery to change one's sex on the birth certificate.
- The addition of gender identity to the current general curriculum taught in schools to improve acceptance and inclusiveness of gender diverse and transgender individuals.
- Provision of gender-affirming treatment of transgender people in the corrections systems regardless of whether they were diagnosed with gender dysphoria prior to or after incarceration.

- sentencing of children, in particular the prohibition of capital punishment and life imprisonment (art. 37 (a)) and the existence of alternative sanctions based on a restorative approach; children deprived of their liberty, and measures to ensure that any arrest, detention or imprisonment of a child shall be used as a measure of last resort and for the shortest appropriate time and that legal and other assistance is promptly provided (art. 37 (b)–(d))

Children in detention

According to ARACY's latest report, the share of children aged 10 – 17 years in detention in Australia on an average day has been trending downwards sitting at 0.3 per 1,000 in 2015-16. At the same time the proportion of youth in prison aged 18 – 24 years has been increasing, reaching 2.7 per 1,000 in 2016. When viewed separately, Aboriginal and Torres Strait Islander children are 25 times more likely to be in detention than non-Indigenous children, and Aboriginal and Torres Strait Islander youth are about 15 times more likely to be in prison than non-indigenous youth.

As outlined in RACP's submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory,[92] youth in the Northern Territory (NT) have the worst health and education outcomes in Australia. As per the recently released 2016 Commonwealth Government Youth Development Index,[93] the NT was ranked the lowest overall, with by far the lowest numeracy and literacy rates with little to no improvement over the past decade; high adolescent fertility rates (97 births per 1000 women aged under 20 years). The NT also had the highest rates of chlamydial infection in Australia; and over half of the youth population reported illicit drug use over the past twelve months. The Index does not include significant health problems specific to the NT Indigenous youth population including rheumatic heart disease where 30% of those affected are under 25 years old.[94]

There is little published data on the health indices of prisoners in the Northern Territory. A 2012 study, instigated by the Acting Superintendent of Darwin Prison at the time, demonstrated alarming rates of hearing loss (97% of participants had significant hearing loss) in adult prisoners.[95]

Youth justice health data collected in other states outlines significant health issues affecting children and adolescents in prison. In 2003, the NSW Department of Juvenile Justice conducted the first Young People in Custody Survey over a six-year period with 242 participants.[96] It involved an initial baseline survey including a health questionnaire, physical health and dental examination, and psychological assessment. This was followed up with surveys at 3, 6 and 12 months. It confirmed that young people in custody experience multiple health problems, including mental illness and drug and alcohol abuse. The poorer health and risk-taking behaviours lead to an increased likelihood of developing chronic disease.

There is an absence of health information available on NT youth in detention, but given the significant health problems identified in broader youth justice literature, the poor health outcomes of NT youth and the overrepresentation of Indigenous youth in detention,[97] it is highly possible that NT youth in the justice system face worse physical and mental health issues than their interstate counterparts. The cost of failure to address

these health issues is likely to be significant, both economically and socially, as this may perpetuate a pathway of unmet health and psychological needs, which can contribute to chronic disease in later years and the next generation.

Discussions with interstate experts have provided an understanding of how youth justice health systems operate elsewhere in Australia. In Victoria, the youth justice service is led by general practitioners with expertise in adolescent health, mental health and substance use. The Western Australian Model includes general practitioners, paediatricians and psychiatrists. In NSW, the service is led by both a child and adolescent psychiatrist and an adolescent physician, though clinical assessments are made by experienced adolescent trained nursing staff who then refer on to Forensic Child and Adolescent psychiatrists and drug and alcohol specialists where appropriate. Regardless of professional composition, all centres operate with professionals who have experience and an understanding of adolescent health needs, and have referral systems in place for assessment and management of substance abuse, and appropriate assessment of mental health disorders.

Refugee and asylum seeker children in immigration detention

Children detained in off shore detention on Nauru are deprived of their liberty. Some children have been there over four years. The conditions in which these children are detained are cruel and degrading. This is because of Australia's off shore detention policy and appears to be in direct contravention of Article 37.

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- administration of juvenile justice (art. 40), the existence of specialised and separate courts and the applicable minimum age of criminal responsibility.

Please refer to our comments on the age of criminal responsibility on page 2 of this submission under article 1.

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