



**Investigation into ways that State government
departments and authorities can prevent or reduce
suicide by young people**

Ombudsman Western Australia
Serving Parliament – Serving Western Australians

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Ombudsman's Foreword

As Western Australian Ombudsman, I review certain child deaths, identify patterns and trends arising from these reviews and make recommendations about ways to prevent or reduce child deaths. Of the child death notifications received by my office since I commenced my child death review responsibility, nearly a third related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for nearly forty per cent of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide. For these reasons, I decided to undertake a major own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by young people.

The objectives of the investigation were to analyse, in detail, deaths of young people who died by suicide notified to my office, comprehensively consider the results of this analysis in conjunction with the relevant research and practice literature, undertake consultation with government and non-government stakeholders and, if required, recommend ways that agencies can prevent or reduce suicide by young people.

I have found that State government departments and authorities have already undertaken a significant amount of work that aims to prevent and reduce suicide by young people in Western Australia, however, there is still more work to be done. I have found that this work includes practical opportunities for individual agencies to enhance their provision of services to young people. Critically, as the reasons for suicide by young people are multi-factorial and cross a range of government agencies, I have also found that this work includes the development of a collaborative, inter-agency approach to preventing suicide by young people. In addition to my findings and recommendations, the comprehensive level of data and analysis contained in this report will, I believe, be a valuable new resource for government departments and authorities to inform their planning and work with young people. In particular, our analysis suggests this planning and work target four groups of young people that we have identified.

Arising from my findings, I have made 22 recommendations to four government agencies about ways to prevent or reduce suicide by young people. I am very pleased that each agency has agreed to these recommendations and has, more generally, been highly co-operative and positively engaged with our investigation.

Suicide by young people is a tragedy. Government agencies, through collaborative policy development and service provision, have a vital role to play in preventing youth suicide. Ultimately, my investigation, and this report, are intended to enhance and improve the way that government agencies undertake this vital work.

Finally, I would like to extend my deepest personal sympathy to the parents, families and communities that have been personally affected by youth suicide in Western Australia.

If you need crisis support, call Lifeline on 13 11 14, or call Kids Helpline on 1800 55 1800, 24 hours a day. For general support, talk to your GP or local health professional. Contact details for other services and information are provided on the following page.

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Crisis Counselling, Support Services and Helpful Information

National 24/7 crisis counselling services

Lifeline: 13 11 14

Suicide Call Back Service: 1300 659 467

For young people 5-25 years:

Kids Helpline: 1800 55 1800

For men of all ages:

MensLine Australia: 1300 78 99 78

Other support services and helpful information

Beyondblue Support Service: 1300 22 4636 or www.beyondblue.org.au

Lifeline: www.lifeline.org.au/Get-Help/

Suicide Call Back Service: www.suicidecallbackservice.org.au

SANE Australia Helpline: 1800 18 SANE (7263) or www.sane.org

For young people

Kids Helpline: www.kidshelp.com.au

ReachOut.Com: www.reachout.com

Headspace: www.headspace.org.au

For people bereaved by suicide

Salvo Care Line: 1300 36 36 22

For people from a culturally and linguistically diverse background

Mental Health in Multicultural Australia: www.mhima.org.au

For Aboriginal and Torres Strait Islander People

Social and Emotional Wellbeing and Mental Health service: www.sewbmh.org.au

For LGBTI, other sexuality, sex and gender diverse people

MindOUT!: www.lgbthealth.org.au/mindout

QLife line: 1800 184 527

Other services

Veterans and Veterans Families Counselling Service: 1800 011 046

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1 Executive Summary

1.1 About the investigation

1.1.1 Functions of the Ombudsman

The Ombudsman has four principal functions derived from his governing legislation, the *Parliamentary Commissioner Act 1971 (the Act)*, and other legislation, codes and service delivery arrangements, as follows:

- Receiving, investigating and resolving complaints about State government agencies, local governments and universities;
- Reviewing certain child deaths and family and domestic violence fatalities;
- Improving public administration for the benefit of all Western Australians through own motion investigations, and education and liaison programs with public authorities; and
- Undertaking a range of additional functions.

1.1.2 The Ombudsman's Child Death Review function

The Ombudsman commenced the review of certain child deaths on 30 June 2009, following the passage of the *Parliamentary Commissioner Amendment Act 2009*. The Ombudsman reviews investigable child deaths. Section 19A(3) of the Act defines an investigable death. For these investigable deaths, the Ombudsman's functions are outlined in section 19B(3) of the Act, as follows:

- (a) to review the circumstances in which and why the deaths occurred;
- (b) to identify any patterns or trends in relation to the deaths;
- (c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

To facilitate the review of investigable child deaths, the Department for Child Protection and Family Support receives information from the State Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to the Department for Child Protection and Family Support by the State Coroner about the circumstances of the child's death together with a summary outlining the Department for Child Protection and Family Support's past involvement with the child.

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide (in this report, young people are defined as those under 18 years of age). The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any State government department or authority about ways to prevent or reduce such deaths.

1.2 Characteristics of the young people who died by suicide

1.2.1 Young people whose deaths were notified to the Ombudsman

- Suicide is defined as the intentional taking of one's own life.¹ This investigation considers young people who died by suicide who were aged between 13 and 17 years.
- The Office of the Ombudsman (**the Office**) analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner has completed an investigation and found that the cause of death was suicide) or was suspected of having died by suicide (for those deaths where the State Coroner has not yet completed an investigation). In this report, these young people are referred to as **the 36 young people**.

1.2.2 Demographic characteristics of the 36 young people

- The 36 young people ranged in age from 14 to 17 years at time of death. Four young people were aged 14 years, 10 were aged 15 years, 11 were aged 16 years and 11 were aged 17 years at time of death.
- Among the 36 young people, 22 (61 per cent) were male and 14 (39 per cent) were female.
- Thirty-three (92 per cent) of the 36 young people were born in Australia. Three young people were born outside Australia.
- Aboriginal young people were significantly over-represented among the 36 young people. Thirteen (36 per cent) of the 36 young people were identified as Aboriginal and 23 (64 per cent) young people were identified as non-Aboriginal. For comparison, six per cent of children and young people aged 0 to 17 years in Western Australia are Aboriginal.²
- The majority of the 36 young people were residing in the metropolitan area of Perth at the time of their death. Using regions defined by the Australian Bureau of Statistics,³ 21 young people were residing in a major city, six young people were residing in an inner regional area, three young people were residing in an outer regional area and six young people were residing in a remote or very remote region. Taking into account the numbers of young people residing in each of these regions, the mortality rates for the 36 young people who died by suicide were as follows:
 - 2.4 per 10 000 young people resided in a major city;
 - 5.4 per 10 000 young people resided in an inner regional area;
 - 3.2 per 10 000 young people resided in an outer regional area; and
 - 10.6 per 10 000 young people resided in a remote or very remote region.

¹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 12.

² Commissioner for Children and Young People, *Groups of children and young people in Western Australia: Wellbeing monitoring framework*, viewed 26 September 2013, <<http://www.ccp.wa.gov.au/maps/map.php>>.

³ Australian Bureau of Statistics, *2011 Census of Population and Housing*, cat. no. 2049.0, ABS, Canberra, 2011.

- Applying the Australian Bureau of Statistics' definition of homelessness,⁴ eight (22 per cent) of the 36 young people experienced at least one form of homelessness at some time in their lives. For comparison, Australian Bureau of Statistics census data reports that in 2011 less than 0.6 per cent of children aged 12 to 18 years were homeless at the census date.⁵

1.2.3 Factors associated with suicide for the 36 young people

- The research literature identifies a range of risk factors, warning signs and precipitating events associated with suicide by young people. These are referred to here as **factors associated with suicide**. While no single cause of suicide has been identified,⁶ the factors associated with suicide have been shown to increase the risk of suicide, particularly when multiple factors are present and interact with each other.⁷ It is important to note that these factors are considered to be correlative, not causal.
- Several factors associated with suicide have already been discussed above as demographic characteristics of the 36 young people, namely, being male and experiencing homelessness. This section discusses the remaining factors associated with suicide experienced by the 36 young people.
- Records indicate that mental health problems were prevalent among the 36 young people:
 - twelve (33 per cent) young people were recorded as having had a diagnosis of mental illness; and
 - fifteen (42 per cent) young people were recorded as having demonstrated self-harming behaviour.
- Records indicate that suicidal ideation and behaviour were also prevalent among the 36 young people:
 - twenty two (61 per cent) young people were recorded as having had thoughts about attempting or completing suicide;
 - twenty (56 per cent) young people were recorded as having communicated their intention to commit suicide to a friend, family member or health professional; and
 - sixteen (44 per cent) young people were recorded as having previously attempted suicide, with six of these young people recorded as having attempted suicide on more than one occasion.

⁴ Australian Government, Department of Health and Ageing, *Homelessness and mental health linkages: review of national and international literature*, Department of Health and Ageing, Canberra, 2005, viewed 26 September 2013, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-homeless-toc~mental-homeless-1-mental-homeless-1-2>>.

⁵ Australian Bureau of Statistics, *2011 Census of Population and Housing: Estimating homelessness*, cat. no. 2049.0, ABS, Canberra, 2011.

⁶ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's business*, Department of Health, Perth, 2009.

⁷ Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 12.

- Child maltreatment consists of any act of commission or omission by a parent or caregiver that results in harm, the potential for harm or the threat of harm to a child, even if the harm is unintentional.⁸ The Office examined allegations of child maltreatment of the 36 young people and found:
 - sixteen (44 per cent) young people were said to have experienced family and domestic violence;
 - nine (25 per cent) young people were recorded as having allegedly experienced sexual abuse;
 - eight (22 per cent) young people were recorded as having allegedly experienced physical abuse; and
 - twelve (33 per cent) young people were recorded as having allegedly experienced one or more elements of neglect during their childhood.
- Records indicate that, among the 36 young people, the frequency of adverse family experiences was:
 - thirteen (33 per cent) young people were recorded as having a parent who had been diagnosed with a mental illness;
 - eight (22 per cent) young people were recorded as having a parent with alleged problematic alcohol or other drug use;
 - five (14 per cent) young people were recorded as having a parent who had been imprisoned; and
 - three (eight per cent) young people were recorded as having a family member who died by suicide and four (11 per cent) had a friend who died by suicide or knew a person who had died by suicide.

1.3 Among the 36 young people who died by suicide, the Office identified four distinct groups of young people

- To analyse the factors associated with suicide, the Office grouped them into the following categories:
 - **Mental health problems**, which included having a diagnosed mental illness and/or self-harming behaviour;
 - **Suicidal ideation and behaviour**, which included suicidal ideation, previous suicide attempts or communicated suicidal intent;
 - **Substance use**, which included alcohol or other drug use;
 - **Experiencing child maltreatment**, which included family and domestic violence, sexual abuse, physical abuse and neglect; and
 - **Adverse family experiences**, which included having a parent with a mental illness, having a parent with alleged problematic alcohol or other drug use, having

⁸ Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 25 February 2014, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.html>>.

a parent who had been imprisoned and having a family member, friend or person known to the young person who died by suicide.

- Through the analysis of the factors associated with suicide experienced by the 36 young people, the Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced. The four groups of young people also demonstrated distinct patterns of contact with State government departments and authorities. In brief, the four groups of young people are:

- **Group 1** - 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Most of the 20 young people in Group 1 were also recorded as having experienced mental health problems and/or suicidal ideation and behaviour.

Records indicate that, as a group, the 20 young people in Group 1 had extensive contact with State government departments and authorities, schools and registered training organisations. All of the young people in Group 1 were known to the Department for Child Protection and Family Support. All had contact with WA Health, with eight young people having contact with the Child and Adolescent Mental Health Service.⁹ Eighteen of the young people had contact with a government school and seven had contact with a registered training organisation. The 20 young people in Group 1 had significant contact with the State government departments and authorities associated with the justice system. The majority also had contact with the Department of Housing.

- **Group 2** - five young people who were recorded as having been diagnosed with one or more mental illnesses, as having a parent who had been diagnosed with a mental illness and/or demonstrated significant planning of their suicide. None of the five young people were recorded as having allegedly experienced child maltreatment.

Records indicate that four out of the five young people in Group 2 had contact with WA Health and Child and Adolescent Mental Health Service. Three of the five young people had contact with a government school and two had contact with a registered training organisation. Records indicate that none of the young people in Group 2 had contact with the Department for Child Protection and Family Support, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

- **Group 3** – six young people who were recorded as having experienced few factors associated with suicide. None of these six young people were recorded as having allegedly experienced any element of child maltreatment, a mental health problem or adverse family experiences. All six young people were recorded as being highly engaged in school and highly involved in sport.

⁹ Child and Adolescent Mental Health Service is a service administered by the Department of Health. For the purposes of this investigation, contact with Child and Adolescent Mental Health Service has been considered separately from other services administered by the Department of Health to identify access to specialised mental health services.

Records indicate that the six young people in Group 3 had minimal contact with State government departments and authorities. Four young people in Group 3 had contact with one State government department, namely WA Health. One young person had contact with a government school and three had contact with registered training organisations. None of the young people in Group 3 had contact with Child and Adolescent Mental Health Service, Department for Child Protection and Family Support, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

- **Group 4** - five young people who, like the young people in Group 3, were recorded as having experienced few factors associated with suicide, except for four young people who were recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. Although none of the five young people were recorded as having allegedly experienced any elements of child maltreatment, a mental health problem or adverse family experiences, the Office observed that all five young people were recorded as having demonstrated impulsive or risk taking behaviour.

Records indicate that the five young people in Group 4 all had contact with WA Health, plus government schools. Four young people had contact with the Department for Child Protection and Family Support and registered training organisations. As a group, the five young people in Group 4 had some contact with the State government departments and authorities associated with the justice system. Two young people had contact with the Department of Housing. None of the five young people in Group 4 had contact with Child and Adolescent Mental Health Service.

1.4 The patterns identified by the Office may have implications for Western Australia's suicide prevention framework

1.4.1 Different suicide prevention activities may be relevant to each of the four groups of young people

- The research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 entitled *The spectrum of interventions for mental health problems and mental disorders (the Mrazek and Haggerty model)*.¹⁰ This model continues to underpin current thinking about suicide prevention strategies. The Mrazek and Haggerty model divides interventions for mental health problems into three categories - Prevention, Treatment and Continuing Care – and further into eight domains within these categories. The Western Australian *Suicide Prevention Strategy 2009-2013: Everybody's Business (the State Strategy)* is informed by the Mrazek and Haggerty model.
- The Office analysed how the patterns in the factors associated with suicide experienced by the 36 young people aligned with the categories and domains of suicide prevention activities as set out in the State Strategy. The Office found that the patterns in the factors associated with suicide experienced by each of the four groups

¹⁰ P Mrazek & R Haggerty (eds), *Reducing risks for mental disorders: Frontiers for preventative intervention research*, National Academy Press, Washington, 1994.

of young people may be aligned with different, albeit overlapping domains of suicide prevention activities. This means that different suicide prevention activities may be relevant to each of the four groups of young people.

Recommendation 1: As part of the development of the State Strategy past 2013, the Mental Health Commission considers developing differentiated strategies relevant to each of the four groups of young people, taking into account the findings of the investigation regarding the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities.

Recommendation 2: The Mental Health Commission, in collaboration with relevant stakeholders, considers whether it may be appropriate to undertake, or facilitate the undertaking of, mental health literacy and suicide prevention activities for those young people who demonstrate few factors associated with suicide, as identified by the investigation.

1.4.2 Preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child maltreatment and mental health problems

- The State Strategy identifies that it is focused on the Prevention category of the Mrazek and Haggerty model, which comprises activities that ‘... can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.’¹¹ The Office’s analysis also indicates that suicide prevention activities in the Prevention category may be important and should continue.
- In addition, the Office found that the factors associated with suicide experienced by 25 (69 per cent) of the 36 young people may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

1.4.3 State government departments and authorities potentially have an important role to play in preventing suicide by young people, including the Department of Health, the Department for Child Protection and Family Support and the Department of Education

- Records indicate that all of the 36 young people had contact with State government departments and authorities at some point in their lives. Records indicate that 31 of the 36 young people (86 per cent) had contact with multiple State government departments and authorities. These 31 young people were across Groups 1 to 4.
- Chapters 7 to 9 of this report contain detailed analysis of the contact by the 36 young people with three State government departments and authorities. These are the Department of Health’s Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. The

¹¹ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody’s Business*, Department of Health, Perth, 2009, p. 30.

findings and recommendations in these chapters largely concern activities that align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model. These recommendations could be considered as part of the development of the State Strategy past 2013.

Recommendation 3: As part of the development of the State Strategy past 2013, the Mental Health Commission gives consideration to whether the scope of the State Strategy should be expanded to encompass the Treatment and Continuing Care categories of suicide prevention, by incorporating the investigation's recommendations about ways that State government departments can prevent or reduce suicide by young people.

1.5 The patterns identified by the Office may have implications for the Department of Health

1.5.1 Twelve of the 36 young people were recorded as having been diagnosed with a mental illness and all were referred for assessment by the Child and Adolescent Mental Health Service at some point in their lives

- The research literature identifies mental illness as a factor associated with suicide. Twelve of the 36 young people were recorded as having been diagnosed with a mental illness. All 12 young people were referred to the Child and Adolescent Mental Health Service (**CAMHS**) at some point in their lives. This contact presents an important opportunity to identify and treat mental illness and, in doing so, assist in preventing and reducing suicide by young people.
- Eight of the 12 young people were also recorded as having allegedly experienced at least one form of child maltreatment. These young people have been included in Group 1. The remaining four young people who were recorded as having been diagnosed with a mental illness were also recorded as having experienced self-harming behaviour, suicidal ideation and previous suicide attempts. However, none of these four young people were recorded as having allegedly experienced child maltreatment or any adverse family experiences other than a parent with a mental illness. These young people have been included in Group 2.
- The Office examined referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for the 12 young people who were recorded as having been diagnosed with a mental illness. The Office found differences between the experiences of the young people in Group 1 and Group 2, particularly with respect to acceptance of referrals by CAMHS and risk assessments. These patterns are discussed below.

1.5.2 By ensuring that the priorities for acceptance of referrals by CAMHS are applied more consistently for all young people, the Department of Health can assist in preventing and reducing youth suicide

- Of the 20 young people in Group 1, eight young people were recorded as having been diagnosed with a mental illness. All eight young people had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives.

- During the last year of their lives, six of the eight young people were referred to CAMHS again. However, three young people were not accepted by CAMHS even though they met the priorities for acceptance set out in the *WA Country Health Service Child and Adolescent Mental Health Services Access Criteria Policy*. The remaining three young people either received services from CAMHS or were waitlisted. Of the five young people in Group 2, four were recorded as having been diagnosed with a mental illness. Records indicate that, these four young people were diagnosed with a mental illness during the last two years of their lives. All four of these young people were referred to CAMHS. All referrals were accepted by CAMHS and the young people referred received services from CAMHS or were waitlisted to receive CAMHS services.

Recommendation 4: The Department of Health considers the findings of this investigation in determining their state-wide provision of mental health services for young people.

Recommendation 5: The Department of Health ensures that the Child and Adolescent Mental Health Service applies the priorities for acceptance of referrals set out in its policies.

Recommendation 6: The Department of Health, where services are available, assists with the coordination of services from other government and non-government mental health services for young people who have been placed on a waitlist for services from the Child and Adolescent Mental Health Service.

Recommendation 7: Where a young person is referred to the Child and Adolescent Mental Health Service but not accepted by the Child and Adolescent Mental Health Service, the Department of Health notifies the referrer that the young person has not been accepted.

1.5.3 By ensuring that risk assessments are conducted more consistently for all young people across WA Health's hospitals and health services, the Department of Health can assist in preventing and reducing youth suicide

- Risk assessments, including risk of harm to self (self-harm and suicide), are required by WA Health's *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards (the CRAM Policy)*.
- For the eight young people in Group 1 who had been recorded as having been diagnosed with a mental illness, risk assessments were not generally undertaken at the three points where they were required by the CRAM policy, as follows:
 - two risk assessments were undertaken as part of four admissions to an inpatient mental health unit; and
 - six risk assessments were undertaken on 14 presentations to an emergency department with self-harm, suicidal ideation and/or behaviour.

- For the four young people in Group 2 who had been recorded as having been diagnosed with a mental illness, risk assessments were generally undertaken in accordance with the CRAM policy, as follows:
 - three risk assessments were undertaken on four admissions to an inpatient mental health unit;
 - five risk assessments were undertaken for six presentations to an emergency department with self-harm, suicidal ideation and/or behaviour;
 - CAMHS undertook three risk assessments after accepting five referrals. These three risk assessments undertaken by CAMHS included a psychosocial and biological component. All three young people for whom a risk assessment had been conducted also had a risk management plan in place.

Recommendation 8: The Department of Health ensures that risk assessments undertaken by the Child and Adolescent Mental Health Service are conducted in accordance with the Clinical Risk Assessment and Management policy and the findings of the Chief Psychiatrist, including for young people who present with a history of child maltreatment.

1.5.4 Aboriginal young people

- Three of the eight young people in Group 1 who had been recorded as having been diagnosed with a mental health illness were Aboriginal. For these three young Aboriginal people:
 - all had been referred to CAMHS and for two young people the referral had been accepted by CAMHS, at some point in their lives;
 - all had been referred to CAMHS on more than one occasion, with a total of 11 referrals for the three young people; and
 - during the last year of their lives, two Aboriginal young people were referred again to CAMHS. Neither of these young people received services from CAMHS as a result of these referrals.
- The research literature has shown the effectiveness of culturally appropriate mental health services successfully engaging Aboriginal young people.¹² This was also recognised in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, which recommended that government:

¹² Australian Institute of Health and Welfare, *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people*, Resource sheet No 19, Australian Institute of Health and Welfare, Canberra, 2013, viewed 24 February 2014, <<http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs19.pdf>>.

Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Services to assist Aboriginal people to access culturally secure Mental Health Services.¹³

- The findings of this investigation support this recommendation.

1.6 The patterns identified by the Office may have implications for the Department for Child Protection and Family Support

1.6.1 Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, and all of these young people had contact with the Department for Child Protection and Family Support

- Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. On the basis of this distinguishing factor, for the purposes of further analysis, these 20 young people are referred to as Group 1.
- Child maltreatment, and its individual forms, has been identified in the research literature as a factor associated with suicide. All of the 20 young people in Group 1 had contact with the Department for Child Protection and Family Support (DCPFS). This contact provides DCPFS with opportunities to recognise and respond to child maltreatment and, in doing so, assist in preventing and reducing suicide by young people.

1.6.2 Seventeen of the 20 young people were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm

- Different forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse and neglect, often co-occur.¹⁴ The effect of experiencing multiple forms of child maltreatment is referred to in the research literature as cumulative harm. Of the 20 young people in Group 1, 17 (85 per cent) were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm.
- The research literature also identifies that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments so as to recognise cumulative harm.¹⁵

¹³ B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Western Australian Department of Health & Mental Health Commission, Perth, 2012, p. 14.

¹⁴ Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 26 September 2013, <<http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html>>.

¹⁵ L Bromfield & D Higgins, 'Chronic and isolated maltreatment in a child protection sample', *Family Matters*, no. 70, 2005, pp. 38 – 45.

- Legislation and policies in some other states and territories explicitly identify that child protection authorities need to undertake holistic assessments so as to recognise cumulative harm. However, there are no explicit legislative requirements in Western Australia for undertaking holistic assessments so as to recognise cumulative harm.
- Some DCPFS policies for responding to child maltreatment address the need to undertake holistic assessments so as to recognise cumulative harm. DCPFS's *Policy on Neglect*¹⁶ explicitly identifies cumulative harm in its operational description of neglect and two further elements of DCPFS's policy framework contain indirect references to cumulative harm. However, the explicit or indirect recognition of cumulative harm has not been extended to other relevant elements of the DCPFS's policy framework.
- DCPFS procedures for responding to information that raises concerns about a child's wellbeing make one direct reference to recognising and responding to cumulative harm. This is contained in DCPFS's *Casework Practice Manual*, which explicitly identifies that a Safety and Wellbeing Assessment should involve 'some or all' of a number of tasks, including 'assess(ing) for the presence or risk of cumulative harm.'¹⁷

Recommendation 9: The Department for Child Protection and Family Support considers whether an amendment to the *Children and Community Services Act 2004* should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.

Recommendation 10: The Department for Child Protection and Family Support considers the revision of its relevant policies and procedures to recognise, consider and appropriately respond to cumulative harm that is caused by child maltreatment.

1.6.3 By assessing the potential for cumulative harm more effectively, DCPFS can assist in preventing or reducing suicide by young people

- All of the 17 young people in Group 1 who were likely to have suffered cumulative harm were known to DCPFS, many through multiple interactions. The Office examined whether, for these 17 young people, DCPFS considered the potential for cumulative harm to have occurred by undertaking holistic assessments.
- The three key stages of DCPFS's procedures are: duty interactions; initial inquiries; and Safety and Wellbeing Assessments. The Office examined the assessments undertaken by DCPFS staff at each of these three stages and found:
 - For the 17 young people who were recorded as having allegedly experienced more than one form of maltreatment, DCPFS received information that raised

¹⁶ Government of Western Australia, Department for Child Protection and Family Support, *Policy on neglect*, DCPFS, Perth, 2012, viewed 26 September 2013, <<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Neglect-PolicyOnNeglect.pdf>>.

¹⁷ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, DCPFS, Perth, 2013, viewed 26 September, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/01SafetyandWellbeingAssessment.aspx>>.

concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an assessment of this information;

- It was not possible to examine whether DCPFS assessed the potential for cumulative harm during the duty interaction process as information which would allow such an assessment to take place is not recorded by DCPFS;
- For 12 young people in Group 1 there were 27 instances of intake and initial inquiries. During these initial inquiries there is evidence that DCPFS assessed the potential for cumulative harm, or progressed to a Safety and Wellbeing Assessment to enable this to be done, in 17 instances. DCPFS did not progress to a Safety and Wellbeing Assessment in two instances. In these two instances, DCPFS did not assess for the potential for cumulative harm; and
- As part of 25 Safety and Wellbeing Assessments, there is evidence that DCPFS assessed the potential for cumulative harm in two Safety and Wellbeing Assessments.

Recommendation 11: The Department for Child Protection and Family Support enables and strengthens staff compliance with the policies and procedures that are applicable to the duty interaction process.

Recommendation 12: The Department for Child Protection and Family Support enables and strengthens staff compliance with any revised policies and procedures which require them to assess the potential for cumulative harm to have occurred as a result of child maltreatment.

1.6.4 Aboriginal young people

- Of the young people in Group 1, Aboriginal young people had higher levels of contact with DCPFS than non-Aboriginal young people, as follows:
 - of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, nine were Aboriginal and eight were non-Aboriginal;
 - 198 (77 per cent) of duty interactions for the young people in Group 1 concerned Aboriginal young people; and
 - of the 12 young people who were the subject of initial inquiries or a Safety and Wellbeing Assessment, seven were Aboriginal and five were non-Aboriginal.
- DCPFS currently engages as a specialist position, Aboriginal Practice Leaders to assist with matters relating to Aboriginal young people. The Case Work Practice Manual sets out specific requirements when the Aboriginal Practice Leader should be consulted. However, this requirement for consultation is generally limited to interactions involving children in the care of the Chief Executive Officer.
- The findings of this investigation indicate that it is also important that Aboriginal Practice Leaders are consulted when the potential for cumulative harm is being assessed for Aboriginal young people, to ensure responses to this are culturally appropriate.

Recommendation 13: In considering revisions to its policies and procedures to recognise cumulative harm, the Department for Child Protection and Family Support considers incorporating requirements to consult with Aboriginal Practice Leaders when the potential for cumulative harm is being assessed for Aboriginal young people.

Recommendation 14: The Department for Child Protection and Family Support uses information developed about young people who are likely to have experienced cumulative harm as a result of child maltreatment to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.

1.7 The patterns identified by the Office may have implications for the Department of Education

- The research literature identifies that educational institutions have an important role to play in reducing the incidence of suicide by young people as education professionals are in a unique position to identify and prevent the suicide of young people.¹⁸ The research literature further identifies that educational institutions are particularly important for children and young people from certain groups, including young people who have experienced child maltreatment, and Aboriginal young people.
- All of the 20 young people in Group 1 were recorded as having allegedly experienced child maltreatment. Nineteen (95 per cent) of the 20 young people were enrolled in an educational program at the time of their death. Of these 19 young people, 17 young people were enrolled in government schools and two were enrolled in non-government schools at the time of their death.

1.7.1 By responding to persistent non-attendance and behaviour management problems more effectively, the Department of Education can assist in preventing or reducing suicide by young people

- During the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60 per cent of the time.
- For the 14 young people who attended school less than 60 per cent of the time, limited actions pursuant to the *School Education Act 1999* and the *Student Attendance* policy were taken to remedy this persistent non-attendance. However a range of other actions, not required by the legislation or policy, were undertaken by schools.

Recommendation 15: The Department of Education ensures that schools comply with the requirements for addressing student non-attendance, as set out in the *School Education Act 1999* and the *Student Attendance* policy.

¹⁸ S. Crawford & N Caltabiano, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education*, vol. 34, no 23, 2009, p. 28.

Recommendation 16: The Department of Education considers expanding its *Student Attendance* policy to:

- recognise that persistent non-attendance by a student may be due to cumulative harm resulting from child maltreatment;
- recognise that these students may be at heightened risk of suicide;
- set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
- provide that, where this association is identified, it will be appropriately taken into account.

- Ten of the 19 young people enrolled at school had been suspended from school.
- Five of the 19 young people enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year.
- For the five young people who had been suspended from school for more than 10 days during a school year, the *Behaviour Management in Schools* policy was not consistently applied. However, a range of other actions, not required by policy were undertaken by schools.

Recommendation 17: The Department of Education ensures that schools comply with the requirements for managing student behaviour, as set out in its *Behaviour Management in Schools* policy.

Recommendation 18: The Department of Education considers the expansion of its *Behaviour Management in Schools* policy to:

- recognise that ongoing behavioural difficulties by a student resulting in multiple suspensions and exclusions may be due to cumulative harm resulting from child maltreatment;
- recognise that these students may be at heightened risk of suicide;
- set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
- provide that, where this association is identified, it will be appropriately taken into account.

1.7.2 Aboriginal young people

- Ten of the 20 young people in Group 1 were Aboriginal. Nine of the ten Aboriginal young people were enrolled with government schools at the time of their death.
- Nine of the ten Aboriginal young people attended school less than 60 per cent of the time in their last year of life. Attendance records for one young person were not available. The attendance patterns of the nine Aboriginal young people where records were available were as follows:
 - three effectively did not attend school in the last year of their life; and
 - six attended school less than 60 per cent of the time in the last year of their life.

- Of the nine Aboriginal young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance, pursuant to the *School Education Act 1999* and the *Student Attendance* policy. However, a range of other actions, not required by the legislation or policy were undertaken by schools.
- Of the ten Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, two were suspended from school for more than 10 days in a school year or excluded from school and limited action was taken under the *Behaviour Management in Schools* policy.

Recommendation 19: The Department of Education ensures that schools comply with the additional requirements for addressing non-attendance by Aboriginal students, as set out in the *Student Attendance* policy.

Recommendation 20: The Department of Education identifies young people who are exhibiting difficulties by establishing internal procedures to track when:

- a young person’s attendance has fallen below 60 per cent;
- a young person’s name has been placed on the Students whose Whereabouts are Unknown list;
- a young person has been suspended from attendance at school on two or more occasions; and
- a young person has been excluded from school.

Recommendation 21: The Department of Education uses the information obtained through tracking attendance, suspensions and exclusions to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.

1.8 State government departments and authorities will need to work together, as well as separately, to prevent and reduce suicide by young people

1.8.1 The importance of sharing information to effective identification of young people at risk of suicide

- In Western Australia, the primary piece of legislation regarding the safety and wellbeing of children is the *Children and Community Services Act 2004 (the CCS Act)*. As identified in a review of the CCS Act, sections 23 and 24A of the CCS Act ‘enable agencies to share information, without consent where necessary, in the interests of the wellbeing of a child or class or group of children.’¹⁹

¹⁹ Government of Western Australia, Department for Child Protection, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 11.

- Some State government departments and authorities indicated that they were aware that information could be shared with DCPFS under the CCS Act and were cooperating with requests for information from DCPFS. However, some State government departments and authorities also reported that they believed the information sharing provisions of the CCS Act only related to exchanges with DCPFS.
- Action Area 4 of the State Strategy identifies the need for practical tools for information sharing. In implementing Action Area 4, the Mental Health Commission could bring together the Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education to develop a tool for identifying young people at risk of suicide, which involves the sharing of information between these three departments in particular, as well as other relevant State government departments and authorities.

1.8.2 The importance of inter-agency collaboration in preventing and reducing suicide by young people who experience multiple risk factors and have contact with multiple State government departments

- Nineteen of the 36 young people (53 per cent) were recorded as having experienced multiple factors associated with suicide and were recorded as having allegedly experienced one or more forms of child maltreatment. Most of these young people were also recorded as having experienced mental health problems and suicidal ideation and behaviour. These 19 young people were all in Group 1. The young people in this group had contact with multiple State government departments and authorities over their lifetime.
- The research literature identifies that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help',²⁰ and agencies face challenges in providing services to these young people.²¹ The profile of 'hard to help' young people described in the research literature was similar to those young people in Group 1.
- Preventing or reducing suicide among young people, such as those in Group 1, who experience multiple risk factors is likely to involve a range of actions by a range of State government departments and authorities, which will need to be coordinated so that each action reinforces the others. One accepted way that such coordination can be achieved is through a case management approach. The young people in Group 1 had significant levels of contact with the Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. These departments could be important parties to a case management approach.

²⁰ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

²¹ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

Recommendation 22: The Mental Health Commission, working together with the Department of Health, the Department for Child Protection and Family Support and the Department of Education, considers the development of a collaborative inter-agency approach, including consideration of a shared screening tool and a joint case management approach for young people with multiple risk factors for suicide.

2 About the investigation

2.1 Role and functions of the Western Australian Ombudsman

2.1.1 Role of the Ombudsman

The Ombudsman is an independent, impartial officer of the Western Australian Parliament who investigates the administration of the laws of Parliament. The Ombudsman reports directly to Parliament, rather than to the government of the day or a particular Minister.

2.1.2 Functions of the Ombudsman

The Ombudsman has four principal functions derived from his governing legislation, the *Parliamentary Commissioner Act 1971 (the Act)* and other legislation, codes and service delivery arrangements, as follows:

- Receiving, investigating and resolving complaints about State government agencies, local governments and universities;
- Reviewing certain child deaths and family and domestic violence fatalities;
- Improving public administration for the benefit of all Western Australians through own motion investigations, and education and liaison programs with public authorities; and
- Undertaking a range of additional functions.

2.2 The Ombudsman's Child Death Review function

The Ombudsman commenced the review of certain child deaths on 30 June 2009 following the passage of the *Parliamentary Commissioner Amendment Act 2009*. The Ombudsman reviews investigable child deaths. Section 19A(3) of the Act defines an investigable death as follows:

An investigable death occurs if a child dies and any of the following circumstances exists –

- (a) in the 2 years before the date of the child's death, the CEO [the Chief Executive Officer of the Department for Child Protection and Family Support] had received information that raised concerns about the wellbeing of the child or a child relative of the child;
- (b) in the 2 years before the date of the child's death, the CEO, under section 32(1) of the CCS Act [*Children and Community Services Act 2004*], had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child;
- (c) in the 2 years before the date of the child's death, any of the actions listed in section 32(1) of the CCS Act was done in respect of the child or a child relative of the child;
- (d) protection proceedings are pending in respect of the child or a child relative of the child;
- (e) the child or a child relative of the child is in the CEO's care.

For these investigable deaths, the Ombudsman's functions are outlined in section 19B(3) of the Act, as follows:

- (a) to review the circumstances in which and why the deaths occurred;
- (b) to identify any patterns or trends in relation to the deaths;
- (c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

To facilitate the review of investigable child deaths, the Department for Child Protection and Family Support receives information from the State Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to the Department for Child Protection and Family Support by the State Coroner about the circumstances of the child's death together with a summary outlining the Department for Child Protection and Family Support's past involvement with the child.

2.3 Rationale for the investigation

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide (in this report, young people are defined as those under 18 years of age). The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any State government department or authority about ways to prevent or reduce such deaths.

2.4 Objectives of the investigation

The objectives of the investigation were to:

- develop a detailed understanding of young people's involvement with State government departments and authorities before their deaths, including the nature and extent of their involvement;
- identify any patterns and trends in: demographic characteristics and social circumstances of young people who died by suicide; the circumstances of the suicides; the risk factors for suicide demonstrated by the young people; and their involvement with State government departments and authorities; and
- based on this understanding, identify ways that State government departments and authorities can prevent or reduce suicide by young people, and make recommendations to these departments and authorities accordingly.

2.5 Methodology

To undertake the investigation, the Office of the Ombudsman (**the Office**):

1. Conducted a literature review;
2. Conducted consultation;
3. Collected and analysed data;

4. Developed a preliminary view; and
5. Developed a final view.

2.5.1 Literature review

The Office conducted a review of relevant national and international literature regarding suicide by young people. The information drawn from this review is referred to as **the research literature** throughout this report.

2.5.2 Consultation

The Office consulted with government and non-government organisations.

2.5.3 Data collection and analysis

The Office analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner has completed an investigation and found that the cause of death was suicide) or was suspected of having died by suicide (for those deaths where the State Coroner has not yet completed an investigation).

The Office collected a significant amount of information about each of the 36 young people from State government departments and authorities, hospitals and health services administered by the Department of Health, non-government schools and registered training organisations. These organisations are listed in Figure 1 below.

The Office comprehensively analysed the information collected using qualitative and quantitative techniques to develop draft findings. The Office also consulted relevant stakeholders regarding the results of this analysis as well as engaging people with expertise in the area of suicide by young people to critically comment on the data collection, analysis and draft findings.

2.5.4 Preliminary view

The Office provided relevant State government departments and authorities with our draft findings and draft recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people.

2.5.5 Final view

Having considered and incorporated comments, where appropriate, by State government departments and authorities, the Office prepared this final report of the investigation to be tabled in the Western Australian Parliament.

Each of the recommendations contained in this report will be monitored by the Ombudsman to ensure their implementation and effectiveness in relation to the findings made in this investigation.

**Figure 1: Organisations from which data was collected
about the young people who died by suicide**

Department of the Attorney General	Department of Training and Workforce Development
Department for Child Protection and Family Support	Disability Services Commission
Department of Corrective Services	Drug and Alcohol Office
Department of Education	Government and non-government schools
Department of Education Services	Government and non-government registered training organisations
Department of Health	Hospitals and health services, which comprise WA Health
Department of Housing	Office of the State Coroner
Department of Local Government and Communities	Western Australia Police

3 Suicide by young people

3.1 Suicide by young people in Western Australia

Suicide is defined as the intentional taking of one's own life.²²

This investigation considers young people who died by suicide who were aged between 13 and 17 years. The Australian Bureau of Statistics reports data about causes of death in five and ten year age groups. The age group used by the Australian Bureau of Statistics that is most relevant to this investigation is the 15 to 19 year age group.

The Australian Bureau of Statistics reports that, in Western Australia in 2011, 22 people aged 15 to 19 years died by suicide.²³ The Australian Bureau of Statistics also reports that, in Western Australia over the period 2007-2011, there were five children aged under 15 years who died by suicide.²⁴

In 2011, the rate of suicide by people aged 15 to 19 years in Western Australia was 14 deaths per 100 000 persons (Figure 2).²⁵ This is almost twice the national rate. Australia-wide, in 2011, 115 people aged 15 to 19 years died by suicide.²⁶ This equates to a rate of suicide by people aged 15 to 19 years in Australia of 7.7 deaths per 100 000 persons.²⁷

²² J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 12.

²³ Australian Bureau of Statistics, *Causes of Death, Australia*, cat. no. 3303.0, customised report, ABS, Canberra, 2010.

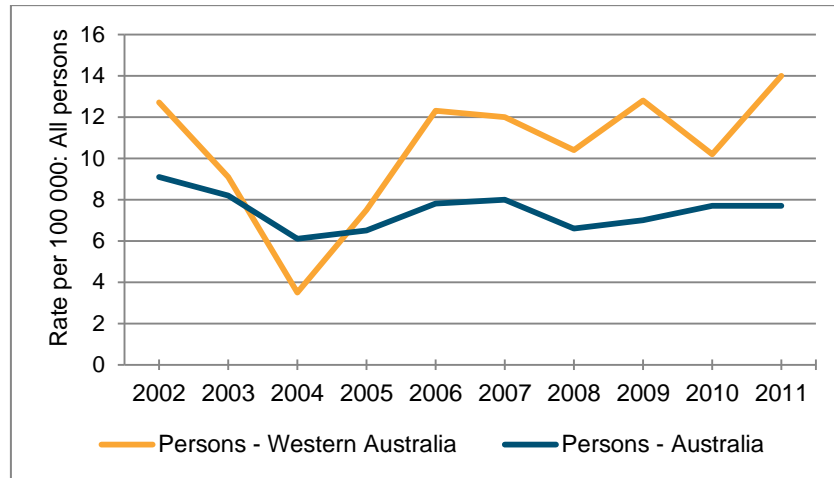
²⁴ Australian Bureau of Statistics, *Causes of Death, Australia, Appendix 1, Table A1.2, Suicide, Number of deaths by age group and state or territory of usual residence, 2007-2011*, ABS, Canberra, 2011.

²⁵ Australian Bureau of Statistics, *Causes of Death, Australia*, cat. no. 3303.0, customised report, ABS, Canberra, 2010.

²⁶ Australian Bureau of Statistics, *Causes of Death, Australia, Table 11.1, Suicide, Number of deaths, 5 year age groups by sex, 2002-2011*, cat. no. 3303.0, ABS, Canberra, 2011.

²⁷ Australian Bureau of Statistics, *Causes of Death, Australia, Table 11.2, Suicide, Age-specific death rates, 5 year age groups by sex, 2002-2011*, cat. no. 3303.0, ABS, Canberra, 2010.

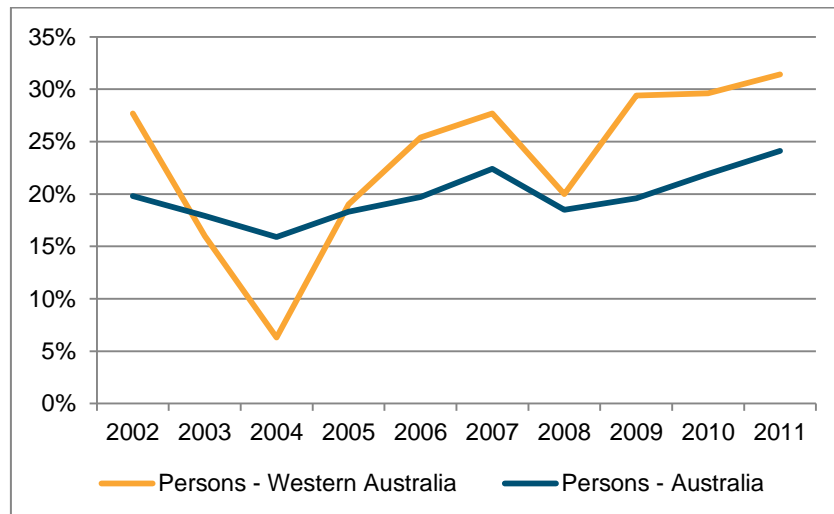
Figure 2: Death by suicide – age specific rates, persons aged 15-19 years, 2002-2011



Source: Australian Bureau of Statistics

Figure 2 also shows that, over the period 2006-2011, the rate of suicide by people aged 15 to 19 years in Western Australia remained fairly steady. However, over that same period, death by suicide as a proportion of all deaths of people aged 15 to 19 years in Western Australia increased (Figure 3).

Figure 3: Death by suicide as a proportion of all deaths, persons aged 15-19 years, 2002-2011



Source: Australian Bureau of Statistics

In 2011, suicide was the most common cause of death of people aged 15 to 19 years in Western Australia. In 2011, suicide accounted for 22 (31.4 per cent) of the deaths of people aged 15 to 19 years, while transport accidents (including motor vehicle, motorcycle and other land transport related accidents) accounted for 16 (22.9 per cent) of the deaths

of people aged 15 to 19 years.²⁸ Australia-wide, in 2011, suicide accounted for almost one quarter (24.1 per cent) of deaths of people aged 15 to 19 years.²⁹

Suicide is also a significant cause of death for people aged 20 to 24 years. Australia-wide, in 2011, 27.8 per cent of all deaths of people aged 20 to 24 years were due to suicide.³⁰ Males aged 85 years and over have the highest rate of suicide (32.1 deaths per 100 000 persons), followed by males aged 80 to 84 years (24.4 deaths per 100 000 persons).³¹

3.2 Young people with higher rates of suicide

The research literature identifies several sub-groups within the 15 to 24 year age group, which have relatively high rates of suicide. These sub-groups are:

- **Young males** – Australia-wide, in 2011, the rate of suicide for males aged 15 to 19 years was 10.4 deaths per 100 000 persons while the rate of suicide for females aged 15 to 19 years was 4.8 deaths per 100 000 persons.³²
- **Aboriginal young people**³³ – across the five Australian states and territories included in the relevant Australian Bureau of Statistics report, in 2011, the rate of suicide for Aboriginal people aged 15 to 24 years was 41.2 per 100 000 persons compared to 8.1 per 100 000 persons for non-Aboriginal people aged 15 to 24 years. (Data for Aboriginal people aged 15 to 19 years old was not available from the Australian Bureau of Statistics).³⁴
- **Young people living in rural and remote communities** – the Australian Institute of Health and Welfare reports that suicide rates for people aged 15 to 24 years living in rural and remote locations throughout Australia are elevated, with this group having a suicide rate three times that of their counterparts living in major cities.³⁵ This is particularly true for young men.³⁶
- **Young people who identify as same-sex attracted and/or transgender** - reliable suicide mortality statistics for young people who identify as same-sex attracted are not available as unlike other demographic characteristics this is not identified in most

²⁸ Australian Bureau of Statistics, *Causes of Death, Australia*, cat. no. 3303.0, customised report, ABS, Canberra, 2011.

²⁹ Australian Bureau of Statistics, *Causes of Death, Australia, Suicide, Proportion of total deaths, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.6, ABS, Canberra, 2011.

³⁰ Australian Bureau of Statistics, *Causes of Death, Australia, Suicide, Proportion of total deaths, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.6, ABS, Canberra, 2011.

³¹ Australian Bureau of Statistics, *Causes of Death, Australia, Suicide, Age-specific death rates, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.2, ABS, Canberra, 2011.

³² Australian Bureau of Statistics, *Causes of Death, Australia, Suicide, Age-specific death rates, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.2, ABS, Canberra, 2011.

³³ The Australian Bureau of Statistics refers to 'Aboriginal and Torres Strait Islander peoples' and 'non-Indigenous' people. In this report, unless taken from a direct quote we refer to Aboriginal and non-Aboriginal people in line with the policy of the Western Australian Government.

³⁴ Australian Bureau of Statistics, *Causes of Death, Australia, Underlying cause of death, Selected causes by Indigenous status, Numbers and Age-Specific Death Rates, Males, Females and Persons, NSW, Qld, SA, WA, NT, 2007-2011*, cat. no. 3303.0, Table 12.4, ABS, Canberra, 2011.

³⁵ Australian Institute of Health and Welfare, *Rural, regional and remote health: A study on mortality, 2nd edition*, Canberra, AIHW, 2007.

³⁶ Australian Institute of Health and Welfare, *Rural, regional and remote health: A study on mortality, 2nd edition*, Canberra, AIHW, 2007.

existing data collections. The research literature indicates that same-sex attracted young people may be up to six times more likely to commit suicide than the general population. Higher rates of suicide are also associated with transgender young people.³⁷

3.3 Explanations of suicide

There is a large body of research literature examining suicide, with much of this research examining suicide by people of all ages. This is discussed below. The following section discusses the research literature that focuses on suicide by young people.

Researchers agree that there are no simple explanations and no single solution for suicide.³⁸ For example, in their report '*Suicide and Suicide Prevention in Australia: Breaking the Silence*', Mendoza and Rosenberg note that the reasons behind a person's decision to commit suicide are 'complex and interrelated' and that the research literature has 'yet to identify a defined, discrete set or constellation of characteristics or circumstances that precipitate suicidal thoughts and/or behaviours'.³⁹

Mendoza and Rosenberg go on to say that 'studies have determined that there are a variety of predisposing or risk factors, warning signs and precipitating events that may increase the risk of suicidal behavior or alert others of the possible risk of suicidality in someone else'.⁴⁰ An explanation of the pathway from risk factors to warning signs, precipitating events and imminent risk, commonly referred to as 'Bycroft's model', is shown in Figure 4 (In the model, Bycroft adopts the term 'tipping points' when referring to precipitating events).

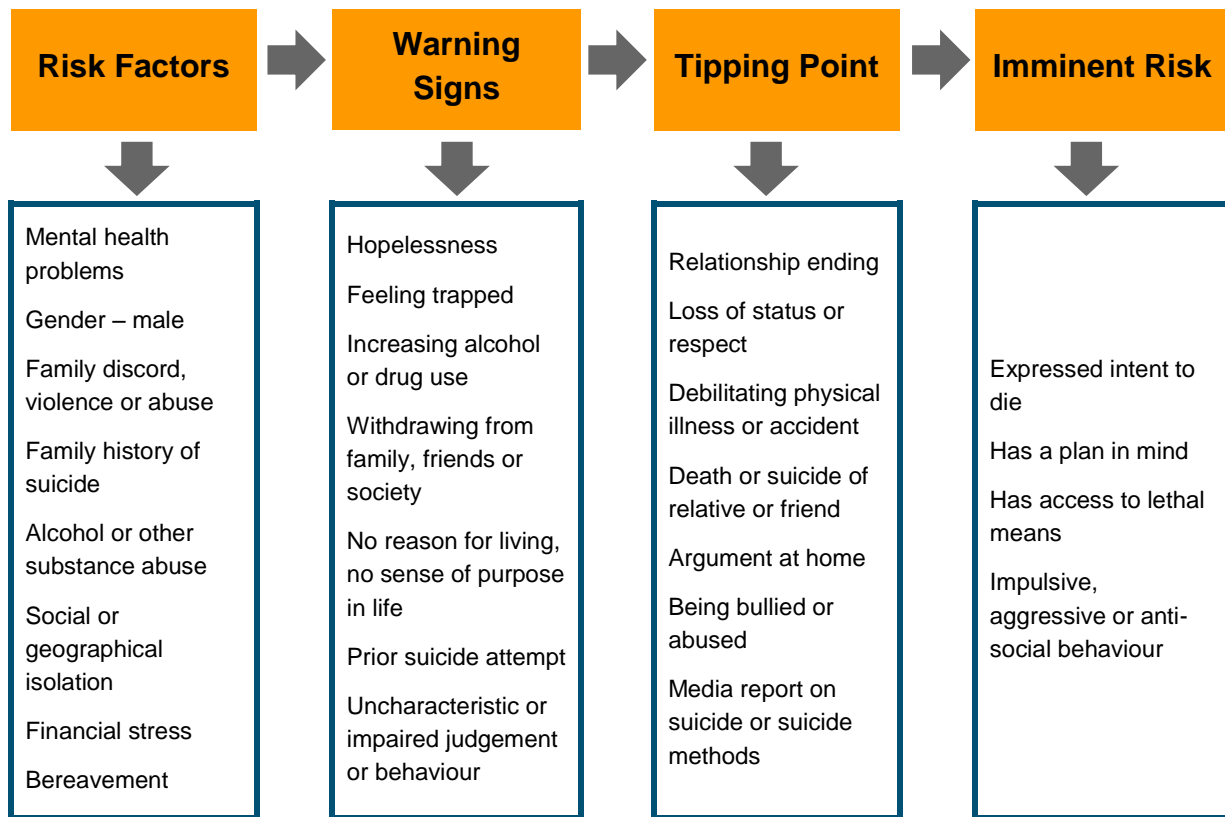
³⁷ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 23; S Dyson, A Mitchell, A Smith, G Dowsett, M Pitts & L Hillier, *Don't Ask, Don't Tell, Hidden in the crowd, The Need for Documenting links between Sexuality and Suicidal Behaviours About Young People*, The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, 2003.

³⁸ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 54; Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 11; Western Australian Government, Department of Health, *Western Australian Suicide Prevention Strategy, 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, Foreword.

³⁹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 55.

⁴⁰ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 55.

Figure 4: The pathway from risk factors to the point of imminent risk



Source: Bycroft 2010⁴¹

3.3.1 Risk and protective factors for suicide

Mendoza and Rosenberg define risk factors as ‘personal characteristics or circumstances that may predispose an individual to suicidal behaviours or increased likelihood of suicidality.’⁴² The identified risk factors are considered to be correlative, not causal. Mendoza and Rosenberg also identify a set of corresponding protective factors, which they define as ‘those characteristics and circumstances that prevent or reduce the likelihood of suicidality.’⁴³

As shown in Figure 5 below, risk and protective factors ‘may be related to the personal characteristics of the individual, events or incidents that have occurred during their life or

⁴¹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 55.

⁴² J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56; E Agerbo, J Sterne & D Gunnell, ‘Combining individual and ecological data to determine compositional and contextual socio-economic risk factors for suicide’, *Journal of Social Science and Medicine*, vol. 64, no. 2, 2007, pp. 451-61; Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 15.

⁴³ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56.

their social environment.⁴⁴ Risk and protective factors generally represent opposite ends of the same concept.⁴⁵

Figure 5: Examples of risk and protective factors⁴⁶

Type of factor	Risk factor	Protective factor
Individual	<ul style="list-style-type: none"> • Sex (male) • Mental illness • Substance abuse • Hopelessness • Poor coping skills • Lack of meaning/purpose in life • Impulsivity 	<ul style="list-style-type: none"> • Sex (Female) • Mental health • No harmful substance use • Positive attitude to life • Adaptive coping skills • Sense of meaning/purpose in life • Controlled Behaviour
Life events or circumstances	<ul style="list-style-type: none"> • Physical, sexual or emotional abuse • Family breakdown/conflict • Social isolation • Family history of suicide/mental illness • Unemployment • Homelessness 	<ul style="list-style-type: none"> • Physical and emotional security • Family harmony • Social connectedness • No family history of suicide/mental illness • Job security • Safe and affordable housing
Social and environmental	<ul style="list-style-type: none"> • Low socio-economic status • Lack of support services • Exposure to environmental stressors (e.g. floods, bushfires, war, global financial crisis) 	<ul style="list-style-type: none"> • Mid to high socio-economic status • Access to support services • Limited exposure to environmental stressors

Source: Mendoza and Rosenberg

The research literature has historically focused on identifying and understanding risk factors. Studies focusing on protective factors and how they can be increased in vulnerable individuals to prevent suicidal behaviour, ‘to better understand what builds resilience and the ability to cope with adverse life events’ have only been undertaken more recently.⁴⁷ Mendoza and Rosenberg point to recent studies that have shown that:

Resilience is by far the most common reaction to adverse life events...However, there are some people who experience greater levels of

⁴⁴ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56.

⁴⁵ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56.

⁴⁶ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 83, adapted from M Barry and R Jenkins, *Implementing mental health promotion*, Elsevier Health Sciences, London, 2007.

⁴⁷ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 57; A Beautrais, ‘Suicide Prevention Strategies 2006’, *Journal for the Advancement of Mental Health*, vol. 5, 2006; D Brent & J Mann, ‘Familial pathways to suicidal behaviour, Understanding and preventing suicide among adolescents’, *New England Journal of Medicine*, vol. 355, 2006, pp. 2719-2721; S Bridge, ‘Suicide prevention - targeting the patient at risk’, *Australian Family Physician*, vol. 35, no. 5, 2006, pp. 335-338.

disruption to their functioning, including those individuals who endure ongoing disruption and dysfunction following the occurrence of negative circumstances (sometimes called *vulnerability*). It has been suggested that it is these individuals who may be at the highest risk of suicidal behaviour.⁴⁸

The research literature has found that the ‘interaction between a person’s predisposing risk factors and protective factors (particularly their level of mental health or illness), their level of vulnerability or resilience and their cumulative experience of negative and positive life events can give an indication of the potential risk of suicide.’⁴⁹ Nevertheless, most people who could be categorised as at risk based on Bycroft’s model, do not follow the pathway to actually commit suicide. In addition, some people who attempt to take their own life have few risk factors and many protective factors. Recent research literature suggests that:

... an understanding of risk factors in suicide is best used to identify populations and specific groups that might be at risk. The main reason is that the majority of people who can be categorized as at risk do not and will not ever choose to take their own life. It is extremely difficult to determine from risk factors alone which individuals within an at-risk group are more or less likely to become suicidal.⁵⁰

3.3.2 Warning signs

The research literature has found that although ‘the majority of people who commit suicide exhibit one or more common warning signs prior to their attempt, unfortunately, most people are unaware of what these warnings signs are and how to respond to them.’⁵¹ As shown in Figure 4, Figure 4 for example, Bycroft’s model identifies a range of warning signs, which are: hopelessness; feeling trapped; increasing alcohol or drug use; withdrawing from family, friends or society; no reason for living; no sense of purpose in life; a prior suicide attempt; and uncharacteristic or impaired judgment or behaviour. For people 15 years and older, symptoms of depression, anxiety disorders and suicide ideation may also be increasingly present.⁵²

3.3.3 Precipitating events

The Australian Government Department of Health and Ageing’s *A Framework for Prevention of Suicide in Australia* describes precipitating events as:

... signposts that give early warning of the potential for someone to take their own life. Sometimes referred to as ‘triggers’ or ‘precipitating events’ they include mental disorders or physical illnesses, alcohol and/or other substance

⁴⁸ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 57.

⁴⁹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 57.

⁵⁰ Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 15.

⁵¹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney 2010, p. 60.

⁵² S Madelyn, T Greenberg, D Velting, D Shaffer & S Gould, ‘Youth Suicide: A Review’, *The Prevention Researcher*, vol. 13, no. 3, 2006, pp. 3-7.

abuse, feelings of interpersonal loss or rejection or the experience of potentially traumatic life events (unexpected changes in life circumstances).⁵³

In one study, for example, suicide attempters reported four times as many negative life events as the general population.⁵⁴

The research literature into suicide by young people in particular identifies the following precipitating events:

- An argument or relationship breakdown usually involving a parent or a partner,⁵⁵
- A stressful life event such as being bullied or having difficulties at school,⁵⁶
- Discharge from an acute psychiatric inpatient unit or any form of custody or detention such as prison,⁵⁷ particularly if there has been previously demonstrated suicidal behaviour;⁵⁸ and
- The modelling, imitation and social transmission of suicidal behaviour (referred to in the research literature as 'contagion'). Research literature has shown that people who know someone who has died by suicide are at a greater risk of dying by suicide or attempting suicide themselves.⁵⁹ This phenomenon is discussed more fully in section 4.2.4.

Another important understanding of suicide that has been considered by this report, particularly the point of imminent risk, has been developed by Thomas Joiner, Professor of Psychology at Florida State University. In 2005, Joiner created the interpersonal-psychological theory of suicidal behaviour, which identifies feelings of isolation and being a burden to others, combined with a desire to die and a lack of fear of dying as 'conditions' for suicide.⁶⁰ Essentially, Joiner puts forward the theory that 'people

⁵³ Australian Government, Department of Health and the Ageing, *A Framework for Prevention of Suicide in Australia*, Canberra, 2008, p. 14.

⁵⁴ E Paykel, B Prusoff & J Myers, 'Suicide attempts and recent life events: A controlled comparison', *Archives of General Psychiatry*, vol. 32, no. 3, 1975.

⁵⁵ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 61.

⁵⁶ M Steele & T Doey, 'Suicidal behaviour in children and adolescents: Part 1, etiology and risk factors', *Canadian Journal of Psychiatry*, vol. 52, 2007; State of Queensland, Commissioner for Children and Young People and Child Guardian, *Reducing Youth Suicide in Queensland Discussion Paper*, Commissioner for Children and Young People and Child Guardian, Brisbane, 2009, p. 11.

⁵⁷ C Kan, T Ho, J Dong & E Dunn, 'Risk factors for suicide in the immediate post-discharge period', *Social Psychiatry and Psychiatric Epidemiology*, vol. 42, no. 3, 2007, pp. 208-214.

⁵⁸ S Pirkola, B Sohlman, H Heila & C Wahlbeck, 'Reductions in post-discharge suicide after deinstitutionalization and decentralization: A nationwide register study in Finland', *Psychiatric Services*, vol. 58, no. 2, 2007, pp. 221-226.

⁵⁹ D De Leo & T Heller, 'Social modeling in the transmission of suicidality', *Crisis, the Journal of Crisis Intervention and Suicide*, vol. 29, no. 1, 2008, pp. 11-19; State of Queensland, Commission for Children and Young People and Child Guardian, *Reducing youth suicide in Queensland Discussion Paper*, Commission for Children and Young People and Child Guardian, Brisbane, 2009; Child Death Review Unit, *Looking for something to look forward to, A five-year retrospective review of child and youth suicide in BC*, British Columbia Coroners Service, 2008.

⁶⁰ T Joiner, 'The Interpersonal-Psychological Theory of Suicidal Behaviour', Current Empirical Status', *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 14 March 2014, <<http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx>>; T Dokoupil, 'The Suicide Epidemic', *Newsweek*, 22 May 2013, viewed 27 February 2014, <http://realtalkrealdebate.wordpress.com/2013/05/30/newsweek-the-suicide-epidemic/>.

will die by suicide when they have both the desire to die and the ability to die.’⁶¹ He went on to distill his theory into the following concepts, which intersect to form Joiner’s theory of suicide:

- Thwarted belongingness (“I am alone”);
- Perceived burdensomeness (“I am a burden”); and
- Capability for suicide (“I am not afraid to die”).⁶²

3.3.4 Risk factors, warning signs and precipitating events for suicide by young people

The research literature identifies a range of risk factors associated with the suicide of young people. In addition to mental illness and substance abuse (that are generally acknowledged to be risk factors for all groups), risk factors for suicide by young people also include sexual and physical abuse, neglect, family and domestic violence, self-harming behaviour and homelessness. Each of these is discussed briefly below.

3.3.4.1 Sexual abuse, physical abuse, neglect and family and domestic violence

The research literature finds that adolescents who are sexually or physically abused in childhood are two to five times more likely to attempt suicide than those who do not have such experiences.⁶³ A 2008 American study identified an association between childhood physical abuse and witnessing domestic violence, and a substantial proportion of psychiatric disorders and suicide related behaviours.⁶⁴ A 2010 Canadian study confirmed the link between physical abuse and suicide-related behaviours in children and young people under 18 years of age.⁶⁵ Neglect in early childhood, impaired parenting and poor family functioning, including parental separations and chronic domestic conflict can also impact on the quality of care for the child leading to increased vulnerability and a heightened risk of suicide.⁶⁶

⁶¹ T Joiner, ‘The Interpersonal-Psychological Theory of Suicidal Behaviour’, Current Empirical Status’, *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 14 March 2014, <<http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx>>; T Dokoupil, ‘The Suicide Epidemic’, *Newsweek*, 22 May 2013, viewed 27 February 2014, <http://realtalkrealdebate.wordpress.com/2013/05/30/newsweek-the-suicide-epidemic/>.

⁶² T Joiner, ‘The Interpersonal-Psychological Theory of Suicidal Behaviour’, Current Empirical Status’, *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 14 March 2014, <<http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx>>; T Dokoupil, ‘The Suicide Epidemic’, *Newsweek*, 22 May 2013, viewed 27 February 2014, <http://realtalkrealdebate.wordpress.com/2013/05/30/newsweek-the-suicide-epidemic/>.

⁶³ S Dube, R Anda, V Felitti, D Chapman, D Williamson & W Giles, ‘Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study’, *Journal of the American Medical Association*, vol. 266, no. 24, 2001, p. 3094; P Mironova, A Rhodes, J Bethell, L Tonmyr, M Boyle, C Wekerle, D Goodman & B Leslie, ‘Childhood physical abuse and suicide-related behaviour: A systemic review’, *Vulnerable Children and Youth Studies*, vol. 6, no. 1, 2011, pp. 1-7.

⁶⁴ T Affi, M Enns, B Cox, G Asmundson, M Stein & J Sareen, ‘Population Attributable Fractions of Psychiatric Disorders and Suicide Ideation and Attempts Associated with Adverse Childhood Experiences’, *American Journal of Public Health*, vol. 98, no. 5, 2008, pp. 946-952.

⁶⁵ S Dube, R Anda, V Felitti, D Chapman, D Dilliamson & W Giles, ‘Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study’, *Journal of the American Medical Association*, vol. 266 no. 24, 2001, p. 3094.

⁶⁶ M Sankey & R Lawrence, *Suicide and risk taking deaths of children and young people*, New South Wales Commission for Children and Young People, Sydney, 2003.

3.3.4.2 Self-harming behaviour

Self-harm is defined as someone deliberately harming themselves without suicidal intent.⁶⁷ Self-cutting and overdose are the most common methods of self-harm in young people, and self-harm is more prevalent in young females than young males.⁶⁸

The research literature finds that self-harm is common among young people, with around 10 per cent of young people reporting self-harming behaviour at some point in their lives.⁶⁹ Since some young people's self-harm does not inflict sufficient physical damage to come to the attention of medical services, self-harm is also believed to be under-reported.⁷⁰

In the vast majority of cases, self-harm by young people is a coping mechanism, not a suicide attempt,⁷¹ and the motivation in many self-harm cases is more to do with an expression of distress and a desire to escape. Even when death is the outcome of self-harming behaviour, this may not have been intended.⁷² Even so, the research literature shows strong links between suicide and self-harm, with between a quarter and a half of people who died by suicide previously carrying out a non-fatal self-harming act.⁷³

3.3.4.3 Homelessness

The research literature also associates a range of other factors with suicide by young people. Homeless young people, for example are more vulnerable to mental illness, self-harm and suicidal ideation.⁷⁴ They are also more likely to use drugs, stay at unsafe or inadequate shelters and engage in unsafe "survival sex" in an effort to find shelter.⁷⁵ They may become homeless as a result of other risk factors for suicide, including abuse, neglect, family and domestic violence or family disunity.⁷⁶ According to a survey of 1,480 homeless young people undertaken by an Australian counselling service in 2009, 48 per cent of young people experiencing homelessness presented with either self-harm or suicidal ideation.⁷⁷

⁶⁷ Lifeline Australia, *Self-harm*, Canberra, 2010, viewed 26 February 2014, <<http://www.lifeline.org.au/Get-Help/Facts---Information/Self-harm/Self-harm>>; F Scanlan & R Purcell, *Mythbuster: Sorting fact from fiction on self-harm*, Headspace National Youth Mental Health Foundation, Australia, 2010, pp. 1-6.

⁶⁸ D De Leo & T Heller, 'Who are the kids who self-harm? An Australian self-report school survey', *Medical Journal of Australia*, vol. 181, no. 3, 2004, pp. 140-144.

⁶⁹ D De Leo, T Heller, 'Who are the kids who self-harm? An Australian self-report school survey', *Medical Journal of Australia*, vol. 181 no. 3, 2004, pp. 140-144.

⁷⁰ K Hawton & A James, 'ABC of adolescence: Suicide and deliberate self-harm in young people', *British Medical Journal*, vol. 330, 2005, pp. 891-94.

⁷¹ F Scanlan & R Purcell, *Mythbuster: Sorting fact from fiction on self-harm*, Headspace National Youth Mental Health Foundation, Australia, 2010, pp. 1-6.

⁷² K Hawton & A James, 'ABC of adolescence: Suicide and deliberate self-harm in young people', *British Medical Journal*, vol. 330, 2005, pp. 891-94.

⁷³ K Hawton & A James, 'ABC of adolescence: Suicide and deliberate self-harm in young people', *British Medical Journal*, vol. 330, 2005, pp. 891-94.

⁷⁴ Headspace National Youth Mental Health Foundation, *Position Paper – Homelessness*, Headspace National Youth Mental Health Foundation Ltd, 21 June 2011, p. 2.

⁷⁵ Kids Helpline, *Information Sheet – Youth Homelessness and Leaving Home*, Brisbane, 19 January 2001, viewed 26 February 2014, <<http://www.kidshelp.com.au/upload/22895.pdf>>.

⁷⁶ A Lamont, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, pp. 1-7.

⁷⁷ Kids Helpline, *Information Sheet – Youth Homelessness and Leaving Home*, Brisbane, 19 January 2001, viewed 26 February 2014, <<http://www.kidshelp.com.au/upload/22895.pdf>>.

3.3.5 Emerging risk factors among young people

It is important to note that there is no definitive list of risk factors. Medical and technological developments, particularly those relevant to young people, have recently led to the identification of additional risk factors. For example, the research literature has identified the following as potential or emerging risk factors for suicide by young people.

- **The use of antidepressants as a treatment for depression in young people** – the research literature has not reached consensus on the effect of antidepressants as a treatment for depression in young people.⁷⁸ Some research literature proposes that antidepressants have limited effectiveness and may actually increase suicidal thinking and behaviour.⁷⁹ Other research literature, on the other hand, claims that the benefits of these drugs outweigh the risks.⁸⁰
- **Media reporting and the impact of social media** - the impact of media reporting and online discussions about suicide on the prevalence of suicide is unknown.⁸¹ Historically, media reports on suicide have been linked to increased suicide attempts in the community.⁸² However, a recent Australian Senate inquiry into suicide of young people, as well as other studies, have found that media reporting and online discussions may also assist in preventing suicide;⁸³ and
- **Cyber bullying, and use of information technology** – the potential risk to young people from the widespread and increasing use of social media for the purposes of cyber bullying and obtaining information on how to attempt suicide is the subject of concern.⁸⁴ Some authors see the use of information technology for these purposes as increasing the risk of suicide, while others point to evidence that the same technology can help in providing options for young people at risk.⁸⁵ In particular, evidence-based, online support services are considered to have the potential to encourage young people to seek help for themselves or their friends and family and reduce the risk of suicide.⁸⁶

⁷⁸ J Leckman, 'The risk and benefits of antidepressants to treat paediatric-onset depression and anxiety disorders: A developmental perspective', *Psychotherapy and Psychomatics*, vol. 82, 2013, p129.

⁷⁹ USA Food and Drug Administration, *Prozac (fluoxetine hydrochloride) capsules label*, Reference ID 2927282.

⁸⁰ R Goldney, 'Suicide and antidepressants: what is the evidence?', *Australian and New Zealand Journal of Psychiatry*, vol. 40, 2006, pp 381-385.; M Clark, K Jansen & J Cloy, 'Treatment of childhood and adolescent depression', *American Family Physician*, vol. 86, no. 5, pp 442-448.

⁸¹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010.

⁸² J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010.

⁸³ House of Representatives Standing Committee on Health and Ageing, *Before it's too late, Report on early intervention programs aimed at preventing youth suicide*, Parliament of Australia, Canberra, 2011; 'There is no 3G in heaven', *Four Corners*, television program, ABC Television, Sydney, broadcast 10 September 2012.

⁸⁴ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 84.

⁸⁵ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 84.

⁸⁶ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 84.

3.4 Suicide by Aboriginal young people

3.4.1 Rates of suicide

The research literature on suicide in Australia is consistent in its identification of Aboriginal people as being at significantly elevated risk of death by suicide when compared to non-Aboriginal people.⁸⁷ The research literature also identifies that this over-representation in suicide deaths is a common feature among the causes of mortality of Indigenous peoples in New Zealand, Canada and the USA, particularly among young Indigenous people.⁸⁸

The Australian Bureau of Statistics reports that between 2001 and 2010, suicides accounted for 4.2 per cent of all registered deaths of people of all ages identified as Aboriginal and Torres Strait Islander people, compared with 1.6 per cent for all Australians in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.⁸⁹ In the same report, the Australian Bureau of Statistics identifies:

The greatest difference in rates of suicide between Aboriginal and Torres Strait Islander people and non-Indigenous people was in the 15-19 years age group for both males and females. Suicide rates for Aboriginal and Torres Strait Islander females aged 15-19 years were 5.9 times higher than those for non-Indigenous females in this age group, while for males the corresponding rate ratio was 4.4...The overall rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females.⁹⁰

The Australian Bureau of Statistics also reports in 2011 that the rate of suicide for Aboriginal and Torres Strait Islander people aged 15 to 24 years was 41.2 per 100 000 persons compared to 8.1 per 100 000 persons for non-Indigenous people in the same age group.⁹¹

⁸⁷ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 76; Government of Australia, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy May 2013*, Canberra, 2013, p. 5.

⁸⁸ G Robinson, S Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies Centre for Child Development and Education, Darwin, 2011, p. 13.

⁸⁹ Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths, 2010*, cat. no. 3309.0, Table 6.1, ABS, Canberra, 2011. The Overview of this Category notes: 'Data from Victoria, Tasmania and the Australian Capital Territory has been excluded to ensure that the information presented is statistically robust. This is in line with reporting approaches currently recommended by the Council of Australian Governments and the national Indigenous Reform Agreement Performance Information Management Group'.

⁹⁰ Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths, 2010*, cat. no. 3309.0, Table 6.1, ABS, Canberra, 2011.

⁹¹ Australian Bureau of Statistics, *Causes of Death, 2011*, cat. no. 3303.0, Table 12.4, ABS, Canberra, 2011. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

3.4.2 Explanations of higher rates of suicide by Aboriginal young people

The Australian Institute of Health and Welfare (AIHW) is Australia's national agency for health and welfare statistics and information.⁹² In its report, *Australia's Health 2010 (the AIHW report)*, AIHW describes socioeconomic factors and their role in influencing individual health and wellbeing. The AIHW report observed that:

Aboriginal and Torres Strait Islander people (Indigenous Australians) generally have significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health. One of the reasons for this poorer health is that Indigenous Australians are socioeconomically disadvantaged compared with other Australians. On average, they report having lower incomes than other Australians, higher rates of unemployment, lower educational attainment, and more overcrowded households. This socioeconomic disadvantage also places Aboriginal and Torres Strait Islander people at greater risk of unhealthy factors such as smoking and alcohol misuse, as well as overweight and obesity.⁹³

In 2008, the Council of Australian Governments (COAG) agreed to six targets relating to Indigenous life expectancy, health, education and employment, collectively known as the 'Closing the Gap initiative'.⁹⁴ These targets are to:

- Close the gap in life expectancy within a generation (by 2030);
- Halve the gap in mortality rates for Indigenous children under 5 years within a decade (by 2018);
- Ensure all Indigenous 4-year olds in remote communities have access to early childhood education within 5 years (by 2013);
- Halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade (by 2018);
- Halve the gap for Indigenous students in Year 12 equivalent attainment by 2020; and
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (by 2018).⁹⁵

⁹² Australian Institute of Health and Welfare, *Australian Institute of Health and Welfare*, Australian Institute of Health and Welfare, Melbourne, viewed 27 February 2014, <<https://www.aihw.gov.au/>>.

⁹³ Australian Institute of Health and Welfare, *Australia's health 2010*, Australia's health series no. 12, cat. no. AUS 122, Canberra, AIHW, 2010.

⁹⁴ Government of Australia, Department of Social Services, *Closing The Gap On Indigenous Disadvantage: The Challenge For Australia*, Department of Social Services, Canberra, 2009.

⁹⁵ Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011*. cat. no. IHW 42. Canberra, 2011.

A study by the Menzies School of Health Research also points to the impact of alcohol misuse on parenting and family relationships⁹⁶ finding that:

[T]he pattern of risk established in early childhood is compounded by ongoing stress within families related to alcohol and cannabis misuse by parents and young adults within many households, ongoing family violence and the failure of many youth to sustain social connection through education, work or other productive activity.⁹⁷

The Royal Commission into Aboriginal Deaths in Custody in 1991 suggested an additional risk factor of particular relevance to Aboriginal people, namely ‘the disproportionate number of [these] deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children.’⁹⁸ The research literature similarly points to the additional disadvantage experienced by Aboriginal people as a result of a history of childhood separation leading to ‘trans-generational family issues, with histories of child removal and foster-care in the parents’ generation, followed by difficult or failed relationships with spouses.’⁹⁹

The Western Australian Aboriginal Child Health Survey describes the effects of this child removal and trans-generational trauma on children as follows:

The experience and effects of forced separation of children from their families and communities have been multiple, continuing and profoundly disabling. The trauma of separation and attempts at “assimilation” have damaged their self-esteem and wellbeing, and impaired their parenting and relationships. In turn their children suffer. There is a cycle of damage which people find difficult to escape unaided.¹⁰⁰

Studies have also found that Aboriginal communities are particularly vulnerable to clusters of suicides.¹⁰¹ The Western Australian Aboriginal Child Health Survey highlights the interconnection of Aboriginal communities and families as relevant here, as follows:

The close-knit nature of Aboriginal communities and the extensive interconnection of families through traditional kinship systems means that the

⁹⁶ G Robinson, S. Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies Centre for Child Development and Education, Darwin, 2011, p. 13.

⁹⁷ G Robinson, S. Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies Centre for Child Development and Education, Darwin, 2011, p. 13.

⁹⁸ Government of Australia, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy May 2013*, Canberra, 2013, p. 10.

⁹⁹ G Robinson, S. Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies School of Health Research, Darwin, 2011, p. 29.

¹⁰⁰ S Zubrick, S. Silburn, D. Lawrence, I. Mitrou, R. Dalby, E. Blair, J. Griffin, H. Milroy, J. De Maio & J. Li, *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute of Child Health Research, Perth, 2005, p. 481.

¹⁰¹ J. Mendoza & S. Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 76; T. Elliott-Farrelly ‘Australian Aboriginal suicide: The need for an Aboriginal suicidology?’, *Australian e-Journal of Mental Health*, vol. 3, 2004, pp. 1-8; Government of Australia, Department of Health and Ageing, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Department of Health and Ageing, Canberra, 2010; Senate Community Affairs Reference Committee, *The Hidden Toll: Suicide in Australia*, Canberra, 2010, p. 91.

death of a young person through suicide can impact on the lives of a considerable number of individuals.¹⁰²

The Menzies School of Health Research study also found:

While general exposure to suicide in communities creates the conditions for modelling and imitation of suicidal behaviour among young people, it is suggested that the rapid escalation of suicide rates among youth and preadolescent children already exposed to some degree of neglect or trauma may be most powerfully influenced by the frequency of suicide threats and attempts within families and households, and of suicide completions in families and within related social networks.....Prior experience of suicidal behaviour in interpersonal conflict combined with the many antecedent difficulties in individuals, families and their relationships may be the most important general preconditions of serious suicide attempts by young people.¹⁰³

Further risk factors identified by the research literature include cultural dislocation, racism and discrimination.¹⁰⁴

Responding to the concerns discussed above, the research literature consistently recommends that there should be a separate suicide prevention strategy for Aboriginal people. The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* was launched by the Australian Government in May 2013. This strategy is discussed in further detail at Chapter 6.

¹⁰² S Zubrick, S Silburn, D Lawrence, I Mitrou, R Dalby, E Blair, J Griffin, H Milroy, J De Maio & J Li, *The Western Australian Aboriginal Child Health Survey: The social and Emotional Wellbeing of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute of Child Health Research, Perth, 2005, p. 356.

¹⁰³ G Robinson, S Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies Centre for Child Development and Education, Darwin, 2011, p. 14.

¹⁰⁴ S Zubrick, P Dudgeon, G Gee, B Glaskin, K Kelly, Y Paradies, C Scrine & R Walker, 'Social Determinants of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing', in N Purdie, P Dudgeon & R Walker, *Working Together: Aboriginal and Torres Strait Islander Health and Wellbeing Principles and Practice*, Office of Aboriginal and Torres Strait Islander Health, Department of Ageing, Canberra, 2010, pp. 75-90.

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4 Characteristics of the young people who died by suicide

4.1 Young people whose deaths were notified to the Ombudsman

The Department for Child Protection and Family Support receives information from the State Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to the Department for Child Protection and Family Support by the State Coroner about the circumstances of the child's death together with a summary outlining the Department for Child Protection and Family Support's past involvement with the child.

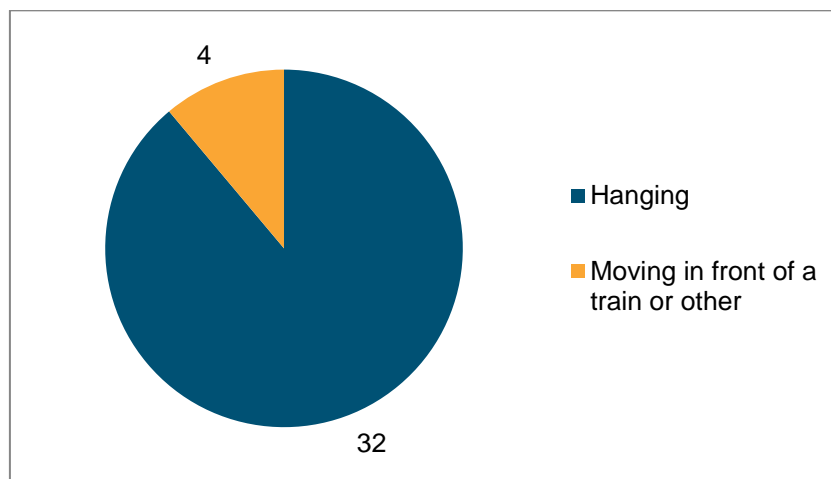
The Office analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner has completed an investigation and found that the cause of death was suicide) or was suspected of having died by suicide (for those deaths where the State Coroner has not yet completed an investigation). In this report, these young people are referred to as **the 36 young people**.

4.2 Circumstances of death

4.2.1 Method of suicide

Among the 36 young people, hanging was the most common method of suicide for both males and females, with 32 (89 per cent) young people using this method (Figure 6). Moving in front of a train was the next most common method of suicide.

Figure 6: Method of suicide, for the 36 young people



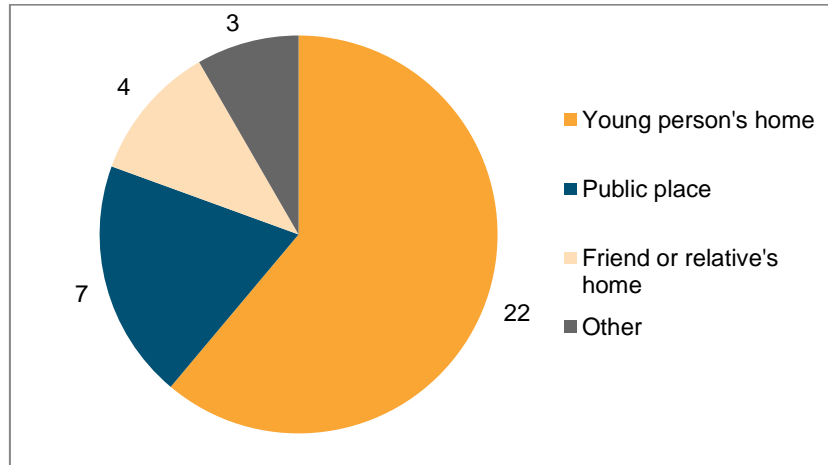
Source: Ombudsman Western Australia

4.2.2 Location of suicide

Among the 36 young people, the most common location of suicide was the young person's home. Twenty two (60 per cent) young people died by suicide in their own home and a further four young people (12 per cent) died by suicide at a relative's or friend's home.

Seven young people (20 per cent) died by suicide in public places including parks, school grounds and community buildings (Figure 7).

Figure 7: Location of suicide, for the 36 young people

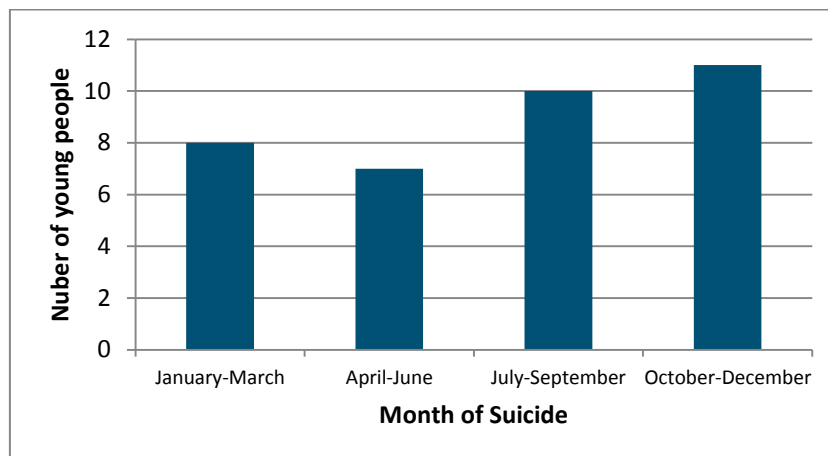


Source: Ombudsman Western Australia

4.2.3 Month of suicide

The figure below shows the average number of deaths by quarter for the 36 young people (Figure 8).

Figure 8: Month of suicide, for the 36 young people



Source: Ombudsman Western Australia

4.2.4 Contagion and suicide clusters

Suicide contagion is a process whereby 'one suicide or suicidal act within a school, community, or geographical area increases the likelihood that others will attempt suicide.'¹⁰⁵ Our investigation indicates that of the 36 young people, three young people had a family member who died by suicide and four young people had a friend, or knew a person, who had died by suicide.

¹⁰⁵ Headspace National Youth Mental Health Foundation, *Suicide Contagion*, Headspace School Support, 2012, viewed 5 March 2014, <<http://www.headspace.org.au/search?q=suicide+contagion>>.

Contagion can also lead to suicide clusters.¹⁰⁶ *The Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business* outlines that there is currently 'no generally agreed upon operational or statistical definition of a suicide cluster,'¹⁰⁷ identifying that the term is loosely defined as a number of suicides or suicide attempts occurring within a close timeframe, and geographical area.¹⁰⁸

Previous investigations have identified that the clustering of suicides has occurred in Western Australia. For example, when conducting an inquest into the deaths of five young people in the Balgo community, the State Coroner found that 'this concentration of suicides in one small community [of Balgo] over a 12 month period clearly constituted a cluster.'¹⁰⁹ These young people were not in the cohort of young people whose deaths were examined by the investigation.

At the time of the investigation, no suicide clusters wholly within the group of 36 young people were identified. However, it is possible that some of the 36 young people were part of a suicide cluster involving other people who were not the subject of this investigation (for example, people who were aged 18 years or over at the time of their death).

4.3 Characteristics examined in this investigation

The remainder of this chapter discusses the characteristics of the 36 young people, drawing on the information collected from State government departments and authorities, schools and registered training organisations during the investigation. A full list of the sources of the information used during this investigation is provided in Figure 1.

The Office drew on the information collected to identify the demographic characteristics of the 36 young people.

The research literature discussed in Chapter 3 identifies a range of risk factors, warning signs and precipitating events associated with suicide by young people. These risk factors, warning signs and precipitating events are referred to here as **factors associated with suicide**. While no single cause of suicide has been identified,¹¹⁰ the factors associated with suicide have been shown to increase the risk of suicide, particularly when multiple factors are present and interact with each other.¹¹¹ The Office was able to draw on the information collected to identify the factors associated with suicide experienced by the 36 young people.

¹⁰⁶ Headspace National Youth Mental Health Foundation, *Suicide Contagion*, Headspace School Support, 2012, viewed 5 March 2014, <<http://www.headspace.org.au/search?q=suicide+contagion>>.

¹⁰⁷ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 21.

¹⁰⁸ Olson, R, *InfoExchange 10: Suicide Conagion and Suicide Clusters*, Centre for Suicide Prevention, Brisbane, 2013, viewed 6 March 2013, < <http://suicideinfo.ca/LinkClick.aspx?fileticket=WXg70KbEYsA%3D>>; State of Queensland Commissioner for Children and Young People and Child Guardian, *Reducing youth suicide in Queensland discussion paper*, Commissioner for Children and Young People and Child Guardian, Brisbane, Queensland, 2009, p. 20; Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 21.

¹⁰⁹ Government of Western Australia, Office of the State Coroner, *Annual Report 2011-2012*, Perth, 2012, p. 38.

¹¹⁰ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 2.

¹¹¹ Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 12.

Figure 9 lists the demographic characteristics and factors associated with suicide that were identified and analysed during the investigation, and are discussed in this report. As discussed in Chapter 3, the research literature identifies some of the demographic characteristics as also being factors associated with suicide.

Figure 9: Demographic characteristics and factors associated with suicide, discussed in this report

<i>Demographic characteristics</i>	
<ul style="list-style-type: none"> • Age • Sex • Country of birth • Aboriginal status¹¹² 	<ul style="list-style-type: none"> • Region of residence • Structure of household • Experience of homelessness
<i>Factors associated with suicide</i>	
<ul style="list-style-type: none"> • Mental illness • Self-harming behaviour • Suicidal ideation • Communicated suicidal intent • Previous suicide attempts • Family and domestic violence • Sexual abuse • Physical abuse 	<ul style="list-style-type: none"> • Neglect • Parent with mental illness • Parent with problematic drug and alcohol use • Parent imprisoned • Family member, friend or person known to the young person died by suicide • Alcohol or other drug use • Experience of a significant event • Use of social media

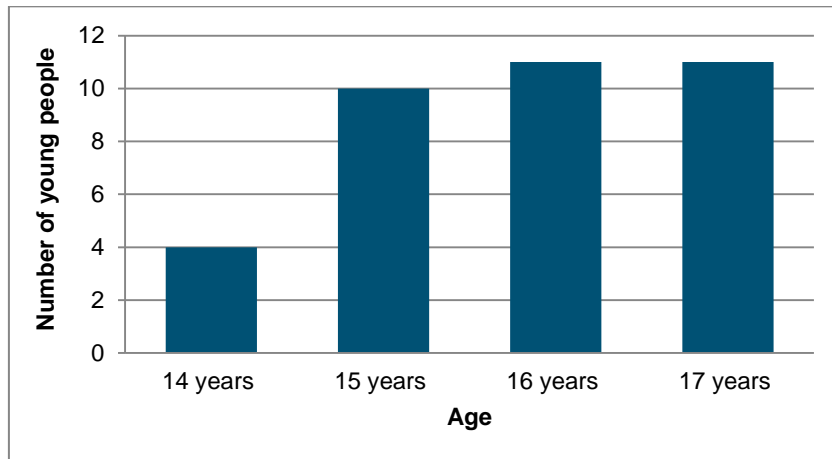
4.4 Demographic characteristics

4.4.1 Age

The 36 young people ranged in age from 14 to 17 years at time of death (Figure 10). Four young people were aged 14 years, 10 were aged 15 years, 11 were aged 16 years and 11 were aged 17 years at time of death.

¹¹² As noted at section 3.4, Aboriginal young people experience elevated rates of suicide.

Figure 10: Age at time of death, for the 36 young people

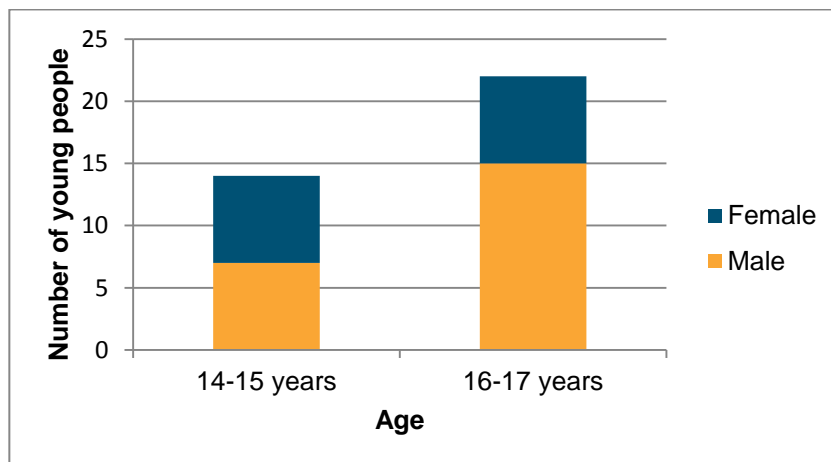


Source: Ombudsman Western Australia

4.4.2 Sex

Among the 36 young people, 22 (61 per cent) were male and 14 (39 per cent) were female (Figure 11). Figure 11 also shows that the number of male suicides was higher among older males, with seven males committing suicide at 14-15 years of age to 15 males committing suicide at 16-17 years of age. Female suicides remained constant at 7 suicides at 14-15 years of age and 16-17 years of age.

Figure 11: Age at time of death by sex, for the 36 young people



Source: Ombudsman Western Australia

4.4.3 Country of birth

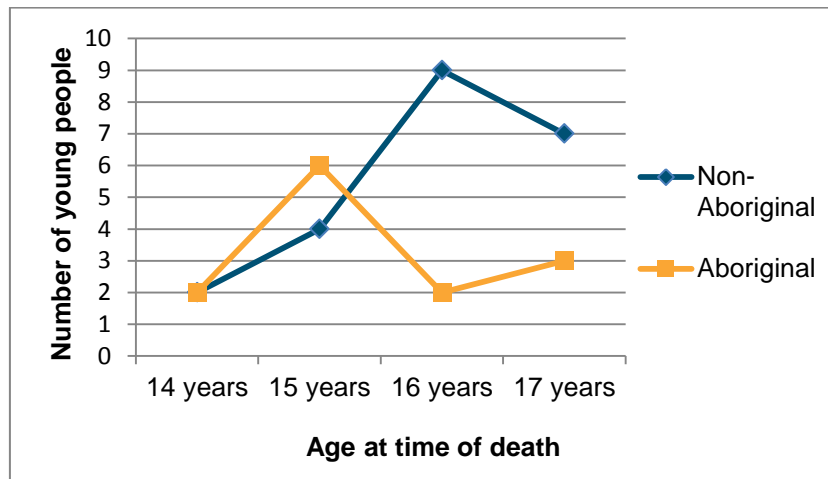
Thirty-three (92 per cent) of the 36 young people were born in Australia. Three young people were born outside Australia.

4.4.4 Aboriginal status

Aboriginal young people are significantly over-represented among the 36 young people. Thirteen (36 per cent) of the 36 young people were identified as Aboriginal and 23 (64 per cent) were identified as non-Aboriginal. For comparison, six per cent of children and young people aged 0 to 17 years in Western Australia are Aboriginal.¹¹³

Among the 36 young people, Aboriginal young people died by suicide at a slightly younger age than non-Aboriginal young people (Figure 12).

**Figure 12: Aboriginal status by age at time of death,
for the 36 young people**

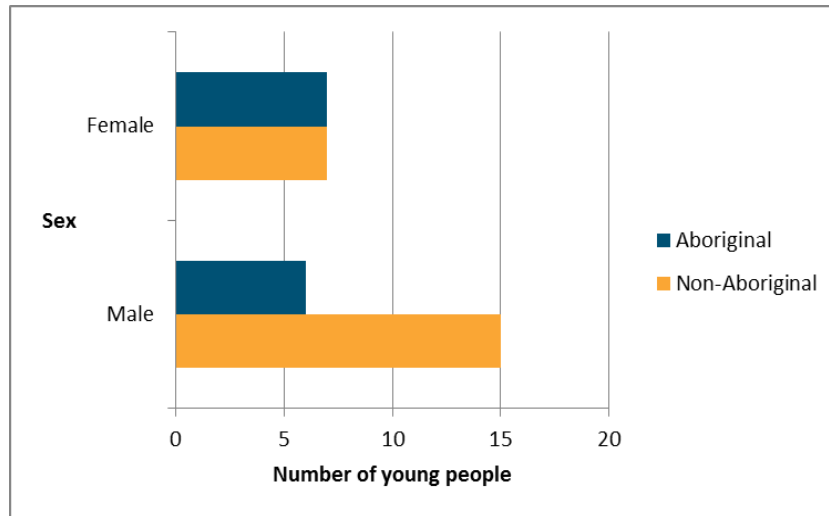


Source: Ombudsman Western Australia

Aboriginal males and Aboriginal females were almost equally represented among the 36 young people with six Aboriginal males and seven Aboriginal females dying by suicide. For comparison, among the 36 young people, just over twice as many non-Aboriginal males died by suicide as non-Aboriginal females (Figure 13).

¹¹³ Commissioner for Children and Young People, *Profile of children and young people in Western Australia*, Perth, 2013, viewed 26 September 2013, <<http://www.ccp.wa.gov.au/maps/map.php>>.

Figure 13: Aboriginal status by sex, for the 36 young people

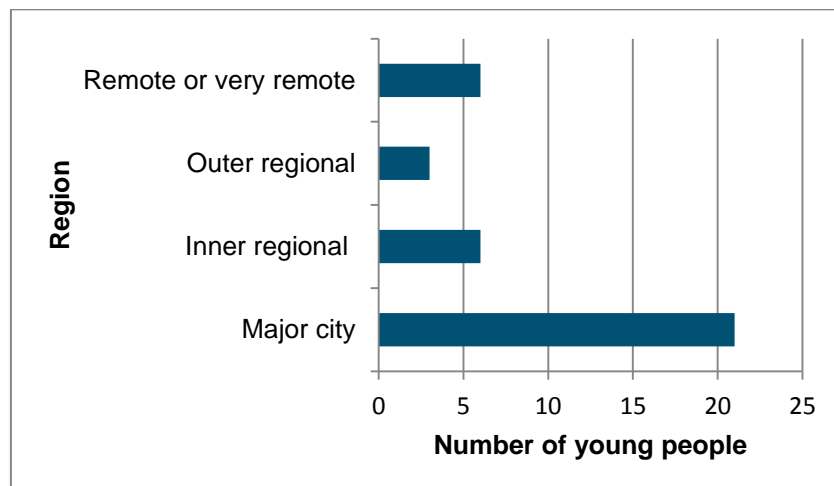


Source: Ombudsman Western Australia

4.4.5 Region of residence

The majority of the 36 young people were residing in the metropolitan area of Perth at the time of their death. Using regions defined by the Australian Bureau of Statistics,¹¹⁴ 21 young people were residing in a major city, six young people were residing in an inner regional area, three young people were residing in an outer regional area, and six young people were residing in a remote or very remote region (Figure 14).

Figure 14: Region of residence at time of death, for the 36 young people



Source: Ombudsman Western Australia

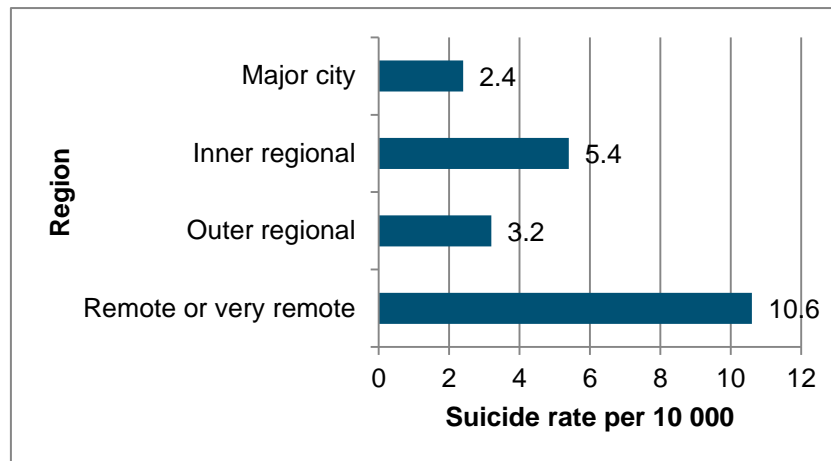
Taking into account the numbers of young people residing in each of these regions, the mortality rates for young people who died by suicide were as follows:

- 2.4 per 10 000 young people resided in a major city;

¹¹⁴ Australian Bureau of Statistics, *2011 Census of Population and Housing*, cat. no. 2049.0, ABS, Canberra, 2011.

- 5.4 per 10 000 young people resided in an inner regional area;
- 3.2 per 10 000 young people resided in an outer regional area; and
- 10.6 per 10 000 young people resided in a remote or very remote region (Figure 15).¹¹⁵

**Figure 15: Suicide rate per 10 000 young people,
for the 36 young people**



Source: Ombudsman Western Australia

4.4.6 Structure of household

Of the 36 young people, 34 resided in households at the time of their death. The structure of these households is set out below:

- thirteen (36 per cent) of the young people came from intact families, living with two biological or foster parents, compared to 73 per cent of surveyed Australian households;¹¹⁶
- three (eight per cent) of the young people came from step or blended families, living with two parents (one biological), compared to seven per cent of surveyed Australian households;
- eleven (31 per cent) came from a one parent household, compared to 20 per cent of surveyed Australian households; and

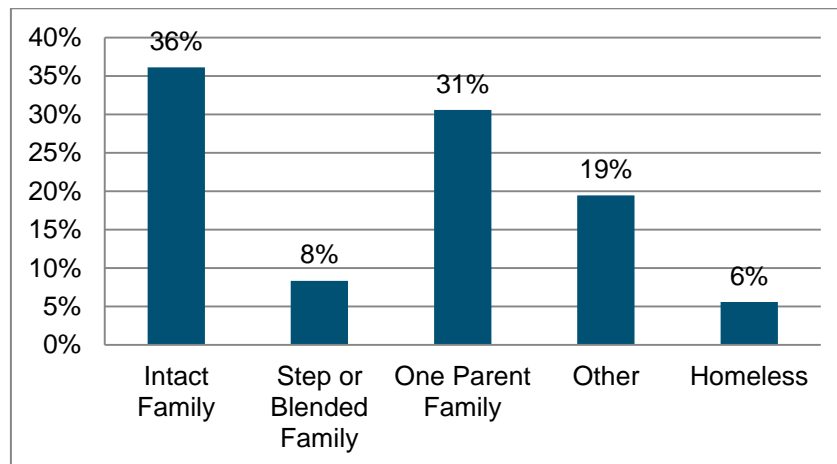
¹¹⁵ Australian Bureau of Statistics, *2011 Census of Population and Housing*, cat. no. 2049.0, ABS, Canberra, 2011.

¹¹⁶ In the financial year 2009-2010 the Australian Bureau of Statistics (ABS) collected information on the topic of Family Characteristics through a 'Multi-Purpose Household Survey'. The ABS survey collected information from randomly selected persons in private dwellings about their household and about every person in the household, including all children: Australian Bureau of Statistics, *Family Characteristics, Australia, 2009-10, Explanatory Notes: Data Collection*, ABS, cat. no. 4442.0, Canberra, 2010, viewed 26 September 2013, <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4442.0Explanatory%20Notes12009-10?OpenDocument>>; The Australian Institute of Family Studies (AIFS) analysed the ABS survey data and reported on the characteristics of households with children under 18 years. The AIFS categorised these households into the various family types used here for comparative purposes: Australian Institute of Family Studies, *Family Facts and Figures: Australian families*, Australian Institute of Family Studies, Melbourne, 2011, viewed 26 September 2013, <<http://www.aifs.gov.au/institute/info/charts/familystructure/index.html#children>>.

- seven (19 per cent) were categorised as coming from an 'other' family type, compared with one per cent of surveyed Australian households. 'Other' families consists of related individuals residing in the same household, however, these individuals do not form a couple or parent-child relationship. For example, a household consisting of a brother and sister only (Figure 16).

Two (six per cent) of the 36 young people were homeless at the time of their death. This is discussed further in section 4.4.7.

**Figure 16: Structure of household,
for the 36 young people**



Source: Ombudsman Western Australia

4.4.7 Experience of homelessness

The Australian Bureau of Statistics uses the following definition of homelessness:

- **Primary homelessness** - people without conventional accommodation such as those who 'sleep out', or use derelict buildings, cars, railway stations for shelter;
- **Secondary homelessness** - people who frequently move from temporary accommodation such as emergency accommodation, refuges, and temporary shelters. People may use boarding houses or family accommodation on a temporary basis; and
- **Tertiary homelessness** - people who live in rooming houses, boarding houses medium or long-term where they do not have their own bathroom and kitchen facilities and tenure is not secured by a lease.¹¹⁷

Applying these definitions, eight (22 per cent) of the 36 young people experienced at least one of these forms of homelessness at some time in their lives. For comparison, Australian

¹¹⁷ Australian Government, Department of Health and Ageing, *Homelessness and mental health linkages: review of national and international literature*, Canberra, 2005, viewed 26 September 2013, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-homeless-toc~mental-homeless-1~mental-homeless-1-2>>.

Bureau of Statistics census data reports that in 2011 less than 0.6 per cent of children aged 12 to 18 years were homeless at the census date.¹¹⁸

4.5 Factors associated with suicide

Several factors associated with suicide have already been discussed as demographic characteristics of the 36 young people.

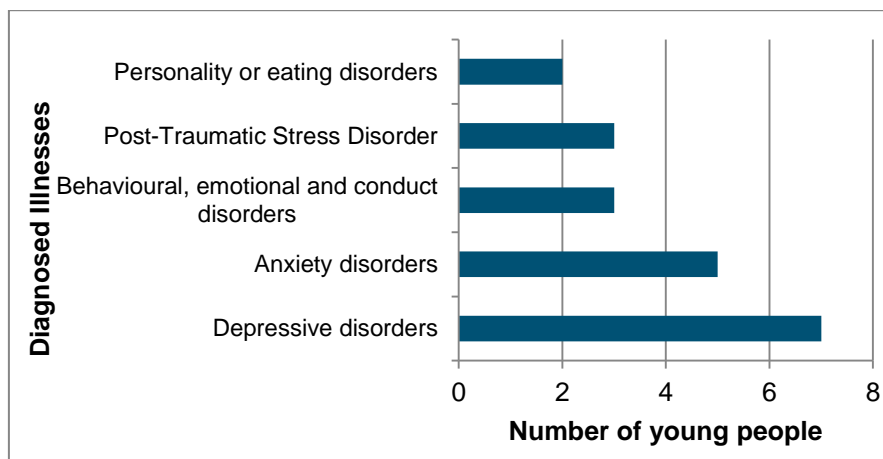
4.5.1 Mental health problems

4.5.1.1 Mental illness

Mental illness is defined as a clinical diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities.¹¹⁹ Twelve (33 per cent) of the 36 young people were recorded as having one or more diagnoses of mental illness. Their recorded diagnosed mental illnesses were as follows (Figure 17):

- Depressive disorders;
- Anxiety disorders;
- Behavioural, conduct and emotional disorders, including Attention Deficit Disorder;
- Post-Traumatic Stress Disorder; and
- Personality and eating disorders, including Anorexia Nervosa and Bulimia Nervosa.

**Figure 17: Recorded diagnoses of mental illness,
for the 36 young people**



Source: Ombudsman Western Australia

¹¹⁸ Australian Bureau of Statistics, *2011 Census of Population and Housing: Estimating homelessness*, cat. no. 2049.0, ABS, Canberra, 2011.

¹¹⁹ Council of Australian Governments, *Improve the mental health and social and emotional wellbeing of all Australians*, Priority 2, Canberra, 2006, p. 17.

4.5.1.2 *Self-harming behaviour*

The research literature recognises self-harm as a form of behaviour in its own right, distinct from suicide. Self-harming behaviour is defined as someone deliberately harming themselves without suicidal intent¹²⁰ as discussed in Chapter 3.

Fifteen (42 per cent) of the 36 young people were recorded as having demonstrated self-harming behaviour.

4.5.2 **Suicidal ideation and behaviour**

4.5.2.1 *Suicidal ideation*

Suicidal ideation is defined by the *Diagnostic and Statistical Manual of Mental Disorders* as recurrent thoughts of death (not just fear of dying) with or without a specific plan for committing suicide.¹²¹ The research literature further describes suicidal ideation as thoughts that life is not worth living, which range in intensity from fleeting thoughts to concrete, well-thought out plans for killing oneself or a complete preoccupation with self-destruction.¹²²

Twenty two (61 per cent) of the 36 young people were recorded as having had thoughts about attempting or completing suicide. For comparison, studies have estimated that between 22 per cent and 38 per cent of young people have thought about suicide at some point in their lives.¹²³

4.5.2.2 *Communicated suicidal intent*

Twenty of the 36 young people (56 per cent) were recorded as having communicated their intention to commit suicide to a friend, family member or health professional.

4.5.2.3 *Previous suicide attempts*

Sixteen (44 per cent) of the 36 young people were recorded as having previously attempted suicide, with six of these young people recorded as having attempted suicide on more than one occasion (Figure 18).

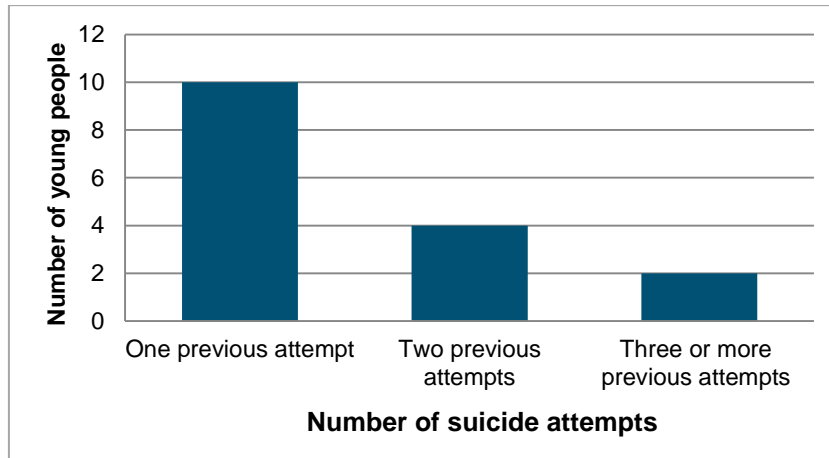
¹²⁰ Lifeline Australia, *Self-harm*, viewed 26 September 2013, <<http://www.lifeline.org.au/Get-Help/Facts---Information/Self-harm/Self-harm>>.

¹²¹ American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 4th ed, Masson, Barcelona, 2003.

¹²² F Scanlan & R Purcell, *Mythbuster, Suicidal ideation, Asking young people about suicidal thoughts or behaviours will only put ideas into their heads*, Headspace, National Youth Mental Health Foundation Australia, 2009, p. 1.

¹²³ F Scanlan & R Purcell, *Mythbuster, Suicidal ideation, Asking young people about suicidal thoughts or behaviours will only put ideas into their heads*, Headspace, National Youth Mental Health Foundation Australia, Melbourne, 2009, p. 1.

**Figure 18: Recorded number of previous suicide attempts,
by the 36 young people**



Source: Ombudsman Western Australia

4.5.3 Experience of child maltreatment

Child maltreatment consists of any act of commission or omission by a parent or caregiver that results in harm, the potential for harm, or the threat of harm to a child (0-18 years of age), even if the harm is unintentional.¹²⁴ In the research literature child maltreatment is commonly divided into five main 'subgroups', including family and domestic violence, sexual abuse, physical abuse, neglect and emotional abuse. The Office examined four forms of child maltreatment: family and domestic violence, sexual abuse, physical abuse and neglect.¹²⁵

4.5.3.1 Family and domestic violence

Family and domestic violence refers to violence involving persons in a family and domestic relationship. A family and domestic relationship is defined by section 4(1) of the *Restraining Orders Act 1997* as being a relationship between two persons:

- (a) who are, or were, married to each other;
- (b) who are, or were, in a de facto relationship with each other;
- (c) who are, or were, related to each other;
- (d) one of whom is a child who —
 - (i) ordinarily resides, or resided, with the other person; or
 - (ii) regularly resides or stays, or resided or stayed, with the other person;
- (e) one of whom is, or was, a child of whom the other person is a guardian; or

¹²⁴Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 25 February 2014, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.htm>>.

¹²⁵ Australian Institute of Family Studies, *What is child abuse and neglect?* Australian Institute of Family Studies, Melbourne, 2012, viewed 26 September 2013, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a142091/>>.

- (f) who have, or had, an intimate personal relationship, or other personal relationship, with each other.

Section 4(2) of the *Restraining Orders Act 1997* defines 'other personal relationship' as a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person. Related, in relation to a person, means a person who:

- (a) is related to that person taking into consideration the cultural, social or religious backgrounds of the 2 persons; or
- (b) is related to the person's —
 - (i) spouse or former spouse; or
 - (ii) de facto partner or former de facto partner.

Section 6(1) of the *Restraining Orders Act 1997* defines acts of family and domestic violence as acts including: assaulting; kidnapping; damaging the person's property (including animals); behaving in an ongoing intimidating, offensive or emotionally abusive manner; pursuing a person with intent to intimidate; and threatening to commit any of the preceding acts.

A child or young person is exposed to family and domestic violence if they see or hear family and domestic violence or experience the effects of family and domestic violence.¹²⁶ In this report this is referred to as 'experiencing' family and domestic violence.

Sixteen (44 per cent) of the 36 young people were said to have experienced family and domestic violence. For comparison, the research literature indicates that an estimated four to 23 per cent of Australian children: witness family and domestic violence; are present while a parent or sibling is subjected to physical abuse, and/or sexual abuse, psychological maltreatment; or are exposed to the damage caused to persons or property by a family member's violent behaviour.¹²⁷

4.5.3.2 *Sexual abuse*

The Department for Child Protection and Family Support defines sexual abuse in relation to a child as including sexual behaviour in circumstances where:

- (a) The child is the subject of bribery, coercion, a threat, exploitation or violence; or
- (b) The child has less power than another person involved in the behaviour; or
- (c) There is a significant disparity in the developmental function or maturity of the child and another person involved in the behaviour.

Sexual abuse occurs when a child has been exposed or subjected to sexual behaviours that are exploitative and/or inappropriate to his/her age and developmental

¹²⁶ Legal Aid Western Australia, *Family violence and family law*, Perth, 2013, viewed 26 September 2013, <<http://www.legalaid.wa.gov.au/InformationAboutTheLaw/DomesticandOtherViolence/Pages/FamilyViolenceAndFamilyLaw.aspx>>.

¹²⁷ D Scott, *The prevalence of child abuse and neglect*, Australian Institute of Family Studies, Melbourne, 2013, viewed 26 September 2013, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a144254/index.html>>.

level. Examples include sexual penetration, inappropriate touching, and exposure to sexual acts or pornographic materials.¹²⁸

Nine (25 per cent) of the 36 young people were recorded as having allegedly experienced sexual abuse.

4.5.3.3 *Physical abuse*

The Department for Child Protection and Family Support defines physical abuse as occurring 'when a child is severely and/or persistently hurt or injured by an adult or a child's caregiver that results in or has the potential to result in physical injury. It may also be the result of putting the child at risk of being injured.' Possible signs of physical abuse include:

- broken bones or unexplained bruises, burns, welts;
- the child is unable to explain an injury or the explanation is vague;
- dehydration or poisoning;
- the child is unusually frightened of a parent or caregiver;
- arms and legs are covered by clothing in warm weather;
- when parents delay getting medical assistance for their child's injury; and
- brain damage through shaking or hitting.¹²⁹

Eight (22 per cent) of the 36 young people were recorded as having allegedly experienced physical abuse.

4.5.3.4 *Neglect*

The Department for Child Protection and Family Support defines neglect as follows:

Neglect is when children do not receive adequate food or shelter, medical treatment, supervision, care or nurturance to such an extent that their development is damaged or they are injured. Neglect may be acute, episodic or chronic. Some examples are:

- Leaving a child alone without appropriate supervision;
- Not ensuring the child attends school, or not enrolling the child at school;
- Infection because of poor hygiene or lack of medication;
- Not giving a child affection or emotional support; [and]

¹²⁸ Government of Western Australia, Department for Child Protection and Family Support, *Fact Sheet 6 – Indicators of child sexual abuse*, DCPFS, Perth, 2008, viewed 26 September 2013, <http://mandatoryreporting.DCP.wa.gov.au/Resource%20Documents/MR_FS6_final_web.pdf>.

¹²⁹ Government of Western Australia, Department for Child Protection and Family Support, *Physical Abuse*, DCPFS, Perth, 2012, viewed 26 September 2013, <<http://www.DCP.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Pages/Physicalabuse.aspx>>.

- Not getting medical help when required.¹³⁰

Twelve (33 per cent) of the 36 young people were recorded as having allegedly experienced one or more of the elements of neglect listed in the Department for Child Protection and Family Support definition during their childhood.

4.5.4 Adverse family experiences

The research literature identifies that adverse family experiences increase the risk of attempted suicide among adolescents.¹³¹ These adverse family experiences are: living with other family members who engage in substance use; are mentally ill; or who have been imprisoned.

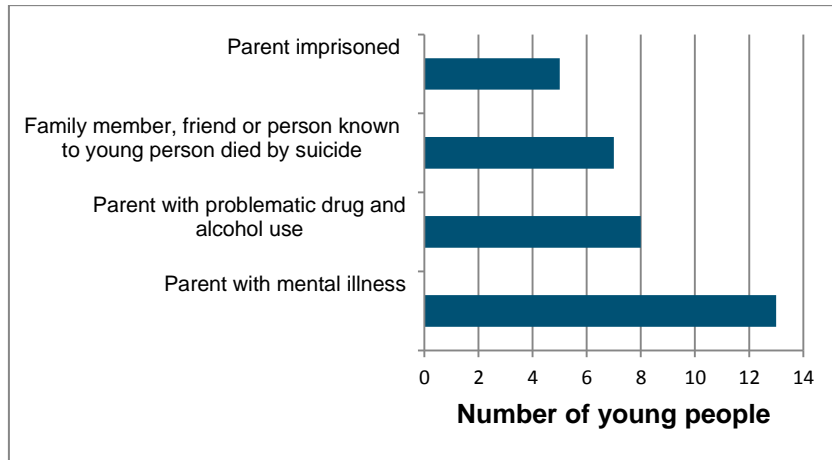
Among the 36 young people, the recorded frequency of adverse family experiences was:

- Thirteen (33 per cent) were recorded as having a parent who had been diagnosed with a mental illness;
- Eight (22 per cent) were recorded as having a parent with alleged problematic alcohol or other drug use;
- Five (14 per cent) were recorded as having a parent who had been imprisoned; and
- Three (eight per cent) were recorded as having a family member who died by suicide and four (11 per cent) had a friend who died by suicide or knew a person who had died by suicide (Figure 19).

¹³⁰ Government of Western Australia, Department for Child Protection and Family Support, *Child Neglect*, DCPFS, Perth, 2012, viewed 26 September 2013, <<http://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Pages/Childneglect.aspx>>.

¹³¹ S Dube, R Anda, V Felitti, D Chapman, D Williamson & W Giles, 'Childhood abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266, no.24, 2001, p. 3089; A Beautrais, 'Risk factors for suicide and attempted suicide among young people', *Australia and New Zealand Journal of Psychiatry*, vol. 34, no. 3, 2000, p. 174.

Figure 19: Recorded adverse family experiences, for the 36 young people

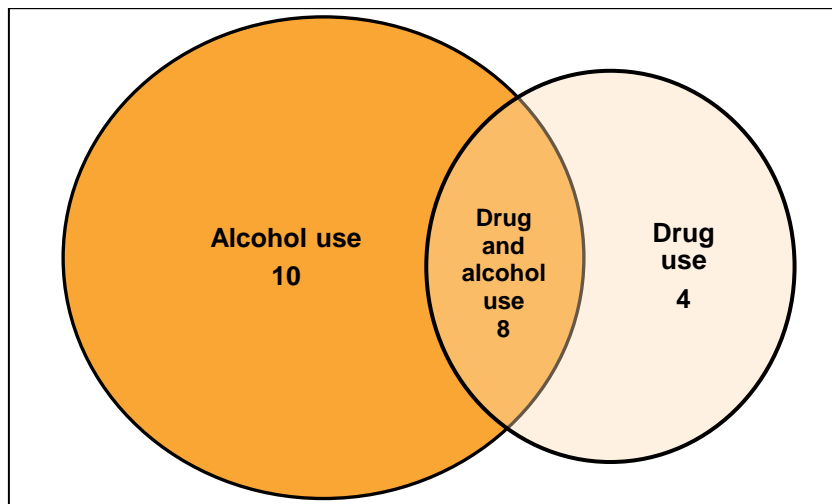


Source: Ombudsman Western Australia

4.5.5 Alcohol or other drug use

The records of State government departments and authorities reviewed during this investigation identified that 22 (61 per cent) of the 36 young people had consumed alcohol and/or other drugs at some point in their lives (Figure 20).

Figure 20: Recorded alcohol or other drug use, by the 36 young people



Source: Ombudsman Western Australia

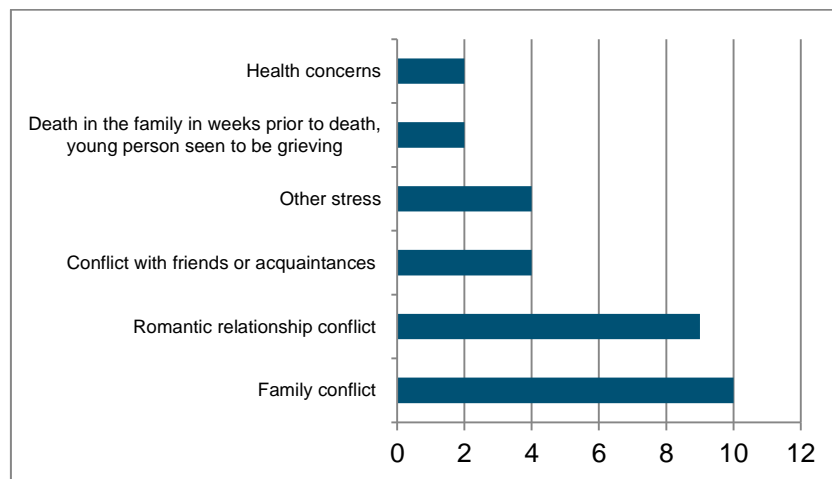
4.5.6 Experience of a significant event

As discussed in Chapter 3, the research literature identifies that many people who attempt suicide experience a precipitating event. Examples of these include an argument or relationship breakdown with a family member or significant person, onset or recurrence of

a mental or physical health problem, an unexpected change in circumstances or a traumatic life event.¹³²

Twenty-four (67 per cent) of the 36 young people were recorded as having experienced one or more significant events in the 48 hours prior to their deaths (Figure 21).

Figure 21: Recorded significant events in the 48 hours prior to suicide, for the 36 young people



Source: Ombudsman Western Australia

4.5.7 Use of social media

Social media are electronic interactive communications facilitated by internet and mobile technologies. Among the 36 young people records indicate that: eight young people (22 per cent) used at least one form of social media in the 24 hours before their death; 13 did not; and for 15 no data is available. The eight young people used a social networking site or micro blog in the 24 hours before death. Three of these eight young people spoke of self-harm and an intention to commit suicide online.

In the 24 hours before death, records indicate that nine of the 36 young people (25 per cent) used their mobile phones, 17 did not and for 10 there is no data available.

¹³² J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, viewed 26 September 2013, <<http://sydney.edu.au/bmri/docs/Breaking-the-Silence.pdf>>.

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5 Patterns in the characteristics of the young people who died by suicide and their contact with State government departments and authorities, schools and registered training organisations

5.1 Introduction

Chapter 4 discusses demographic characteristics and the risk factors, warning signs and precipitating events, referred to as **factors associated with suicide**, experienced by the 36 young people. To analyse the factors associated with suicide, the Office grouped them into the categories shown in Figure 22 below.

Figure 22: Factors associated with suicide and corresponding categories used in this report

Category	Factors associated with suicide
Mental health problems	<ul style="list-style-type: none"> • Mental illness • Self-harming behaviour
Suicidal ideation and behaviour	<ul style="list-style-type: none"> • Suicidal ideation • Previous suicide attempts • Communicated suicidal intent
Substance use	<ul style="list-style-type: none"> • Alcohol or other drug use
Child maltreatment	<ul style="list-style-type: none"> • Family and domestic violence • Sexual abuse • Physical abuse • Neglect
Adverse family experiences	<ul style="list-style-type: none"> • Parent with a mental illness • Parent with problematic alcohol or other drug use • Parent who had been imprisoned • Family member, friend or person known to the young person died by suicide

Source: Ombudsman Western Australia

Through this analysis, the Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced. In brief, the four groupings of young people are:

Group 1 - twenty young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Most of the 20 young people in Group 1 were also recorded as having experienced mental health problems and suicidal ideation and behaviour.

Group 2 – records indicate that five young people who were recorded as having been diagnosed with one or more mental illnesses, as having a parent who had been diagnosed

with a mental illness and/or demonstrated significant planning for their suicide. None of the five young people were recorded as having allegedly experienced child maltreatment.

Group 3 – records indicate that six young people experienced few factors associated with suicide. None of these six young people were recorded as having allegedly experienced any element of child maltreatment, a mental health problem or adverse family experiences. All six young people were recorded as being highly engaged in school and highly involved in sport.

Group 4 – records indicate that five young people, like the young people in Group 3, experienced few factors associated with suicide. None of the five young people were recorded as having allegedly experienced any elements of child maltreatment, a mental health problem or adverse family experiences. However, the records indicated that all five young people demonstrated impulsive or risk taking behaviour.

This chapter discusses these four groups of young people in more detail. A summary of their contact with State government departments and authorities is also provided. The table below sets out the definition of ‘contact’ used during this discussion. It also shows the acronyms used.

Organisation	Definition of 'contact' as indicated by the records
Child and Adolescent Mental Health Service (CAMHS) ¹³³	Young person was the subject of a referral received by CAMHS, or received services from CAMHS.
Department for Child Protection and Family Support (DCPFS)	Young person was the subject of an interaction with DCPFS; young person directly communicated with DCPFS; or young person was the subject of protection action by DCPFS (including being in the care of the CEO). In this report, if a young person had contact with DCPFS, or was part of a family who had contact with DCPFS, we refer to this situation as the young person being known to DCPFS .
Department of Corrective Services (DCS)	Young person was referred to a DCS service by Western Australia Police officers under section 27 of the <i>Young Offenders Act 1994</i> ; young person was referred by a court under section 28 of the <i>Young Offenders Act 1994</i> ; or young person served time in a custodial facility.
Department of Housing (Housing)	Young person was part of a family that lodged an application for, or received services from Housing.
Department of the Attorney General (DOTAG)	Young person received an offer of services from DOTAG's Child Witness Service or Victim Support Services.
Government (Gov't. schools)	Young person was enrolled with a government school as their last school. Enrolment with non-government schools is also discussed in each section.
Government and non-government registered training organisations (RTO)	Young person participated in an educational program delivered by a government or non-government registered training organisation.
WA Health	Young person received treatment from a hospital Emergency Department; young person received treatment as an inpatient or outpatient of WA Health, except Child and Adolescent Mental Health Service, which are shown separately.
Western Australia Police (WAPOL)	Young person was the subject of a report by WAPOL to DCPFS; young person was charged with an offence by WAPOL.

By understanding the groups of young people and their patterns of contact with State government departments and authorities, the Office has been able to identify ways that

¹³³ The Child and Adolescent Mental Health Service is a service administered by the Department of Health. For the purpose of this investigation, contact with Child and Adolescent Mental Health Service has been considered separately from contact with other health services administered by the Department of Health to identify access to specialised mental health services.

State government departments or authorities can potentially prevent or reduce suicide by young people. These are discussed in Chapters 6 to 10.

The patterns described in this chapter are consistent with similar investigations by Child Death Review teams from New South Wales,¹³⁴ Queensland,¹³⁵ and British Columbia, Canada,¹³⁶ which identified two 'groupings' of young people:

- Young people who had experienced significant enduring life difficulties including mental health problems, family dysfunction, school related difficulties or any combination of these factors. This group made up 66 per cent to 80 per cent of cases across the three studies; and
- Young people who had experienced a precipitating or 'life changing' event in the absence of chronic family, relationship or mental health problems. This group made up 20 to 26 per cent of cases reviewed across the three studies.

The British Columbia study further categorised the first grouping of young people into young people who had ongoing mental health problems (45 per cent of the cases) and young people experiencing chronic dysfunction in their interpersonal relationships (44 per cent of cases).¹³⁷

5.2 Young people in Group 1

5.2.1 Factors associated with suicide

The Office identified that 20 (56 per cent) of the 36 young people were recorded as having experienced multiple factors associated with suicide. All of these 20 young people were recorded as having allegedly experienced some form of child maltreatment including family and domestic violence, sexual abuse, physical abuse or neglect. Nineteen of these 20 young people were recorded as having allegedly experienced child maltreatment in conjunction with other factors associated with suicide, including suicidal ideation (16 young people), mental health problems (14 young people), substance use (14 young people) and adverse family experiences (13 young people). In this report, this grouping of young people is referred to as **Group 1**.

The factors associated with suicide experienced by the young people in Group 1 are summarised in Figure 23 below.

¹³⁴ M Sankey & R Lawrence, *Suicide and risk-taking deaths of children and young people*, New South Wales Commissioner for Children and Young People, Sydney, 2003.

¹³⁵ State of Queensland, Commissioner for Children and Young People and Child Guardian, *Reducing youth suicide in Queensland Final Report*, Commissioner for Children and Young People and Child Guardian, Brisbane, 2011.

¹³⁶ Government of British Columbia, Child Death Review Unit, *Looking for something to look forward to: A five-year retrospective review of child and youth suicide in BC*, Child Death Review Unit, Burnaby, 2008.

¹³⁷ Government of British Columbia, Child Death Review Unit, *Looking for something to look forward to: A five-year retrospective review of child and youth suicide in BC*, Child Death Review Unit, Burnaby, 2008, p. vii.

Figure 23: Young people in Group 1 – overview of factors associated with suicide

Child maltreatment	Young person 1	Young person 2	Young person 3	Young person 4	Young person 5	Young person 6	Young person 7	Young person 8	Young person 9	Young person 10	Young person 11	Young person 12	Young person 13	Young person 14	Young person 15	Young person 16	Young person 17	Young person 18	Young person 19	Young person 20
Suicidal ideation and behaviour																				
Mental health problems																				
Substance use																				
Adverse family experiences																				

Source: Ombudsman Western Australia

More detail about the factors associated with suicide experienced by the young people in Group 1 is provided below.

Child maltreatment

Records indicate that, of the 20 young people in Group 1:

- seventeen were said to have experienced family and domestic violence;
- nine were recorded as having allegedly experienced sexual abuse;
- eight were recorded as having allegedly experienced physical abuse; and
- twelve were recorded as having allegedly experienced elements of neglect, including:
 - eight young people were recorded as allegedly not having been given assistance when required;
 - seven young people were recorded as allegedly not having been given affection or emotional support;
 - four young people were recorded as allegedly having experienced infection because of poor hygiene or lack of medication; and
 - three young people were recorded as allegedly having been left alone without appropriate supervision.

- Suicidal ideation and behaviour** Records indicate that, of the 20 young people in Group 1:
- thirteen demonstrated suicidal ideation;
 - twelve communicated their intention to commit suicide to a friend, family member or health professional; and
 - twelve had previously attempted suicide, with four of these young people previously attempting suicide on more than one occasion.
- Mental health problems** Records indicate that, of the 20 young people in Group 1:
- eleven self-harmed;
 - eight were diagnosed with a mental illness including Depressive disorders, Post Traumatic Stress Disorder, Anxiety disorders or Conduct disorders;
 - six were prescribed medication for a diagnosed mental illness, as follows:
 - five were prescribed anti-depressant medication;
 - two were prescribed anti-psychotic medication; and
 - three were prescribed medication used to treat Attention Deficit Disorder.
- Substance use** Records indicate that, of the 20 young people in Group 1:
- eleven consumed alcohol at some time in their lives;
 - nine consumed illicit drugs at some time in their lives; and
 - toxicology reports indicated that seven consumed alcohol or cannabis prior to their deaths.
- Adverse family experiences** Records indicate that, of the 20 young people in Group 1:
- ten had a parent with a mental illness;
 - eight had a parent who had problematic alcohol and other drug use;
 - five had a parent who was imprisoned; and
 - six had a family member, friend or person known to them who had died by suicide.

5.2.2 Demographic characteristics

Records indicate that, of the 20 young people in Group 1:

- ten (50 per cent) were male and 10 (50 per cent) were female;
- ten (50 per cent) were Aboriginal and 10 (50 per cent) were non-Aboriginal;
- ten (50 per cent) were aged 14 to 15 years and ten were aged 16 to 17 years;

- ten (50 per cent) resided in a major city, six (30 per cent) resided in a regional area and four (20 per cent) resided in a remote or very remote region; and
- with respect to structure of household:
 - three (15 per cent) lived in either an intact family or a step or blended family;
 - seven (35 per cent) lived in one parent families;
 - seven (35 per cent) lived with relatives other than parents; and
 - three (15 per cent) lived in other circumstances.

5.2.3 Contact with State government departments and authorities, schools and registered training organisations

Records indicate that, as a group, the 20 young people in Group 1 had extensive contact with State government departments and authorities, schools and registered training organisations, as set out in Figure 24. This figure shows that all of the young people in Group 1 were known to the Department for Child Protection and Family Support. All had contact with WA Health, with eight young people having contact with Child and Adolescent Mental Health Service. Eighteen of the young people had contact with a government school and seven had contact with a registered training organisation.

Figure 24: Young people in Group 1 - overview of contact with State government departments and authorities, schools and registered training organisations¹³⁸

WA Health																				
DCPFS																				
Gov't. school																				
WAPOL																				
Housing																				
CAMHS																				
DCS																				
RTO																				
DOTAG																				
	Young person 1	Young person 2	Young person 3	Young person 4	Young person 5	Young person 6	Young person 7	Young person 8	Young person 9	Young person 10	Young person 11	Young person 12	Young person 13	Young person 14	Young person 15	Young person 16	Young person 17	Young person 18	Young person 19	Young person 20

Source: Ombudsman Western Australia

More detail about the contact by the 36 young people with the Department for Child Protection and Family Support, schools and registered training organisations, and WA Health's Child and Adolescent Mental Health Service is provided below.

5.2.3.1 Department for Child Protection and Family Support (DCPFS)

Records indicate that, of the 20 young people in Group 1, all had contact with DCPFS, or were part of a family who had contact with DCPFS. We refer to this situation as the young person being **known to DCPFS**. Of the 20 young people in Group 1:

- sixteen were known to DCPFS because the Department had received information that raised concerns about the wellbeing of the young person;
- four were known to DCPFS solely through a parent's application for financial assistance or because DCPFS had received information that raised concerns about the wellbeing of the young person's sibling or through a Western Australia Police notification.

¹³⁸ In this figure the acronyms refer to the following: **WA Health** WA Health (not including CAMHS, which is shown separately); **DCPFS** Department for Child Protection and Family Support; **Gov't. school** government schools; **WAPOL** Western Australia Police; **Housing** Department of Housing; **CAMHS** Child and Adolescent Mental Health Service; **DCS** Department of Corrective Services; **RTO** government and non-government registered training organisations; **DOTAG** Department of the Attorney General.

Information provided to DCPFS relating to the wellbeing of young people in Group 1 encompassed a number of issues:

- child maltreatment allegations, including allegations of family and domestic violence, sexual abuse, physical abuse and neglect;
- parent with problematic alcohol or other drug use;
- absconding from places of care;
- access to adequate food or medical care; and
- concerns raised by a member of the public about parenting of a young person.

Reports to DCPFS originated from a number of sources, including members of the community such as family members or neighbours, and from a range of professionals who had contact with the young people or their families. This included:

- Western Australia Police officers;
- Teachers, psychologists or administrative staff of schools;
- Staff of a hospital or medical centre;
- Staff of the Department of Corrective Services; and
- Staff of a non-government organisation (for example a youth centre, refuge or homeless service provider).

Further analysis of the contact between the young people in Group 1 and DCPFS, and the implications of this analysis, is discussed in Chapter 8.

5.2.3.2 *Child and Adolescent Mental Health Service (CAMHS)*

Records indicate that, of the 20 young people in Group 1, eight had been referred by a general practitioner or staff of a hospital emergency department to CAMHS. Four of these young people were also admitted to hospital for a mental illness.

Further analysis of the contact between the young people in Group 1 and CAMHS, and the implications of this analysis, is discussed in Chapter 7.

5.2.3.3 *Schools and registered training organisations*

Records indicate that, of the 20 young people in Group 1:

- eighteen were enrolled with a government high school as their last school; and
- two were enrolled with a non-government high school as their last school.

Records indicate that, of the 20 young people in Group 1, seven had contact with a registered training organisation:

- five young people had contact with a government registered training organisation in their school; and
- two young people had contact with a government registered training organisation on the campus of the registered training organisation.

Further analysis of the contact between the young people in Group 1 and schools and registered training organisations, and the implications of this analysis, is discussed in Chapter 9.

5.2.3.4 *Contact with other State government departments and authorities*

Records indicate that the 20 young people in Group 1 had significant contact with the justice system and associated State government departments and authorities. Fifteen of the 20 young people had contact with Western Australia Police at some point in their lives. Thirteen young people were the subject of reports by Western Australia Police to DCPFS raising concerns about the safety or wellbeing of the young person (discussed at section 5.2.3.1 above). Nine of the 15 young people were charged by Western Australia Police with one or more offences. Three of the nine young people who had been charged with an offence were charged on multiple occasions.

Records indicate that seven of the 20 young people in Group 1 had contact with the Department of Corrective Services. All seven young people were referred to Juvenile Justice Teams. Three young people also spent time on remand in a custodial facility.

Records indicate that the majority of young people in Group 1 also had contact with the Department of Housing. Fourteen of the 20 young people had contact as follows:

- at the time of their death, seven young people were listed with the Department of Housing as registered householders;
- three young people had also been registered householders in the past but were no longer registered at the time of their death; and
- four young people were listed on applications for public housing that were later withdrawn.

Further details about contact by the 36 young people with other State government departments and authorities is provided in the Appendix.

5.3 Young people in Group 2

5.3.1 Factors associated with suicide

The Office identified that records indicate that five (14 per cent) of the 36 young people were diagnosed with one or more mental illnesses and/or demonstrated significant planning of their suicide. Four of these five young people were recorded as having been diagnosed with multiple mental illnesses and three of the five young people were recorded as having a parent who had been diagnosed with a mental illness. None of the five young people were recorded as having allegedly experienced any other types of adverse family experiences or any elements of child maltreatment (as defined in section 4.5.3). In this report, this grouping of young people is referred to as **Group 2**.

The factors associated with suicide experienced by the young people in Group 2 are summarised in Figure 25 below.

Figure 25: Young people in Group 2 – overview of factors associated with suicide

Suicidal ideation and behaviour					
Mental health problems					
Adverse family experiences¹					
Substance use					
Child maltreatment					
	Young person 21	Young person 22	Young person 23	Young person 24	Young person 25

Source: Ombudsman Western Australia

Note 1: The only type of 'adverse family experience' for the young people in Group 2 was a parent diagnosed with a mental illness.

More detail about the factors associated with suicide experienced by the young people in Group 2 is provided below.

Suicidal ideation and behaviour

Records indicate that, of the five young people in Group 2:

- all five demonstrated suicidal ideation;
- three communicated their intention to commit suicide to a friend, family member or health professional; and
- two had previously attempted suicide.

Mental health problems

Records indicate that, of the five young people in Group 2:

- four had diagnoses of multiple mental illnesses:
 - all four young people were diagnosed with depression, as well as a second mental illness including anxiety or personality disorders. All four had also self-harmed; and
 - all four young people had been prescribed with anti-depressant medication. Two of the four young people had been prescribed with anti-depressant medication combined with anti-psychotic medication.

Adverse family experiences Records indicate that, of the five young people in Group 2:

- three had a parent who had been diagnosed with a mental illness; and
- none had a parent who was imprisoned, a parent who had problematic alcohol or other drug use; or a family member, friend or person known to them who had died by suicide.

Substance use Records indicate that, of the five young people in Group 2, two had consumed alcohol and/or illicit drugs at some time in their lives.

Child maltreatment Records indicate that none of the young people in Group 2 were recorded as having allegedly experienced any child maltreatment that is, family and domestic violence, neglect, sexual abuse, and/or physical abuse.

5.3.2 Demographic characteristics

Records indicate that, of the five young people in Group 2:

- three were female and two were male;
- all five were non-Aboriginal;
- their ages ranged from 15 to 17 years;
- all were residing in either a major city or an inner regional area; and
- all were living with either both biological parents or one biological parent.

5.3.3 Contact with State government departments and authorities, schools and registered training organisations

Records indicate that four out of five (80 per cent) young people in Group 2 had contact with WA Health and CAMHS. Three of the five young people had contact with a government school and two had contact with a registered training organisation, as shown in Figure 26.

Records indicate that none of the young people in Group 2 had contact with the Department for Child Protection and Family Support, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

Figure 26: Young people in Group 2 - overview of contact with State government departments and authorities¹³⁹

WA Health					
CAMHS					
Gov't. school					
RTO					
DCPFS					
DCS					
DOTAG					
Housing					
WAPOL					
	Young person 21	Young person 22	Young person 23	Young person 24	Young person 25

Source: Ombudsman Western Australia

More detail about the contact by the young people in Group 2 with CAMHS, schools and registered training organisations is provided below.

5.3.3.1 *Child and Adolescent Mental Health Service (CAMHS)*

Records indicate that the four young people in Group 2 who had been diagnosed with a mental illness all presented at CAMHS following referral by a general practitioner.

Further analysis of the contact between the young people in Group 2 and CAMHS, and the implications of this analysis, is provided in Chapter 7.

5.3.3.2 *Schools and registered training organisations*

Records indicate that of the five young people in Group 2:

- three were enrolled with a government high school as their last school; and
- two were enrolled with a non-government school as their last school.

¹³⁹ In this figure the acronyms refer to the following: **WA Health** WA Health (not including CAMHS, which is shown separately); **DCPFS** Department for Child Protection and Family Support; **Gov't. school** government schools; **WAPOL** Western Australia Police; **Housing** Department of Housing; **CAMHS** Child and Adolescent Mental Health Service; **DCS** Department of Corrective Services; **RTO** government and non-government registered training organisations; **DOTAG** Department of the Attorney General.

Records indicate that, of the five young people in Group 2, two were, or had been, enrolled with a registered training organisation on the campus of the registered training organisation or in their school.

5.4 Young people in Group 3

5.4.1 Factors associated with suicide

Records indicate that six (17 per cent) of the 36 young people experienced few factors associated with suicide, except for two young people who were recorded as having experienced suicidal ideation. None of the six young people were recorded as having adverse family experiences, were recorded as having allegedly experienced any elements of child maltreatment or were recorded as having been diagnosed with a mental illness.

However, the Office observed similarities in other characteristics of the six young people. Records indicate that, all of the six young people were highly engaged in school, with each being acknowledged for their high academic performance, either through awards for academic distinction and excellence, by being observed by teachers as bright or intelligent or being discussed for academic acceleration. Each young person was also highly involved in a sporting activity. In this report, this grouping of young people is referred to as **Group 3**.

The factors associated with suicide experienced by the young people in Group 3 are summarised in Figure 27 below.

Figure 27: Young people in Group 3 – overview of factors associated with suicide

Suicidal ideation and behaviour						
Substance use						
Adverse family experiences						
Child maltreatment						
Mental health problems						
	Young person 26	Young person 27	Young person 28	Young person 29	Young person 30	Young person 31

Source: Ombudsman Western Australia

More detail about the factors associated with suicide experienced by the young people in Group 3 is provided below.

Suicidal ideation and behaviour

Records indicate that, of the six young people in Group 3, two demonstrated suicidal ideation and/or their intention to commit suicide to a friend, family member, or health professional.

Substance use	Records indicate that, of the six young people in Group 3, two had consumed alcohol at some time in their lives.
Child maltreatment	Records indicate that none of the young people in Group 3 were recorded as having allegedly experienced any child maltreatment, that is, family and domestic violence, sexual abuse, physical abuse and neglect.
Mental health problems	Records indicate that none of the young people in Group 3 were diagnosed with a mental illness or self-harmed.
Adverse family experiences	Records indicate that none of the six young people in Group 3 had a parent with a mental illness; a parent who was imprisoned; a parent who had problematic alcohol and other drug use; or had a family member, friend or person known to them who had died by suicide.

5.4.2 Demographic characteristics

Records indicate that, of the six young people in Group 3:

- all were male;
- all were non-Aboriginal;
- their ages ranged from 15 to 17 years;
- five (83 per cent) resided in a major city; and
- four were living with two biological parents and two were living with one biological parent or living in a step family with two parents.

5.4.3 Contact with State government departments and authorities, schools and registered training organisations

Records indicate that the six young people in Group 3 had minimal contact with State government departments and authorities, as shown in Figure 28. The figure shows that the young people in Group 3 had contact with one State government department, namely WA Health, plus one government school and several registered training organisations.

None of the young people in Group 3 had contact with CAMHS, DCPFS, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

Figure 28: Young people in Group 3 - overview of contact with State government departments and authorities¹⁴⁰

WA Health						
RTO						
Gov't. schools						
CAMHS						
DCPFS						
DCS						
DOTAG						
Housing						
WAPOL						
	Young person 26	Young person 27	Young person 28	Young person 29	Young person 30	Young person 31

Source: Ombudsman Western Australia

More detail about contact by the young people in Group 3 with schools and registered training organisations is provided below.

5.4.3.1 Schools and registered training organisations

Records indicate that, of the six young people in Group 3:

- five were enrolled with a non-government school as their last school; and
- three had contact with a registered training organisation in their school or on the campus of the registered training organisation.

¹⁴⁰ In this figure the acronyms refer to the following: **WA Health** WA Health (not including CAMHS, which is shown separately); **DCPFS** Department for Child Protection and Family Support; **Gov't. school** government schools; **WAPOL** Western Australia Police; **Housing** Department of Housing; **CAMHS** Child and Adolescent Mental Health Service; **DCS** Department of Corrective Services; **RTO** government and non-government registered training organisations; **DOTAG** Department of the Attorney General.

5.5 Young people in Group 4

5.5.1 Factors associated with suicide

Records indicate that, like the young people in Group 3, five (14 per cent) of the 36 young people experienced few factors associated with suicide, except for four young people who demonstrated suicidal ideation and behaviour and/or engaged in substance use. None of the five young people were recorded as having experienced adverse family experiences, were recorded as having allegedly experienced any elements of child maltreatment or were recorded as having a mental health problem or having been diagnosed with a mental illness.

However, the Office observed similarities in the experiences of the young people in this group. Records indicate that all five young people in this Group demonstrated behaviours that could be considered impulsive or risk taking, including:

- substance use;
- suspension from school for physical assault, verbal abuse, harassment or intimidation of staff;
- engaging in criminal activity;
- engaging in unprotected sex on repeat occasions, with multiple partners; and
- driving a motor vehicle under the influence of alcohol.

In this report, we refer to this grouping of young people as **Group 4**.

The factors associated with suicide experienced by the young people in Group 4 are summarised in Figure 29 below.

Figure 29: Young people in Group 4 – overview of factors associated with suicide

Suicidal ideation and behaviour					
Substance use					
Adverse family experiences					
Child maltreatment					
Mental health problems					
	Young person 32	Young person 33	Young person 34	Young person 35	Young person 36

Source: Ombudsman Western Australia

More detail about the factors associated with suicide experienced by the young people in Group 4 is provided below.

Suicidal ideation and behaviour	Records indicate that, of the five young people in Group 4: <ul style="list-style-type: none">• three demonstrated suicidal ideation;• three communicated their intention to commit suicide to a friend, family member, or health professional; and• two had previously attempted suicide.
Substance use	Records indicate that, of the five young people in Group 4: <ul style="list-style-type: none">• three consumed alcohol or illicit drugs at some time in their lives; and• two young people consumed alcohol in the 24 hours prior to their death.
Adverse family experiences	Records indicate that, none of the five young people in Group 4 had a parent with a mental illness, a parent who was imprisoned, a parent who had problematic alcohol or other drug use, or had a family member, friend or person known to them who had died by suicide.
Child maltreatment	Records indicate that, none of the young people in Group 4 were recorded as having allegedly experienced any elements of any child maltreatment that is family and domestic violence, sexual abuse, physical abuse or neglect.
Mental health problems	Records indicate that, none of the young people in Group 4 were diagnosed with a mental illness or self-harmed.

5.5.2 Demographic characteristics

Records indicate that of the five young people in Group 4:

- four were male and one was female;
- three were Aboriginal;
- their ages ranged from 14 to 17 years;
- two resided in a major city and three resided in either a regional area, remote or very remote region; and
- all young people were living with either both biological parents or one biological parent.

5.5.3 Contact with State government departments and authorities, schools and registered training organisations

Records indicate that the five young people in Group 4 had contact with a range of State government departments and authorities, plus government schools and registered training organisations, as shown in Figure 30.

Figure 30: Young people in Group 4, overview of contact with State government departments and authorities¹⁴¹

WA Health					
Gov't. schools					
DCPFS					
RTO					
WAPOL					
Housing					
DCS					
DOTAG					
CAMHS					
	Young person 32	Young person 33	Young person 34	Young person 35	Young person 36

Source: Ombudsman Western Australia

As shown above, records indicate that the five young people in Group 4 had some contact with the justice system and associated agencies. Three young people had contact with Western Australia Police (either as the subject of a Western Australia Police notification to DCPFS or through being charged with an offence) or were offered support services for victims of crime by the Department of the Attorney General.

Records indicate, of the five young people in Group 4, two had been listed as registered householders with the Department of Housing in the past but were no longer listed as registered householders at the time of their death. None of the five young people in Group 4 had contact with CAMHS.

More details about contact by the young people in Group 4 with the Department for Child Protection and Family Support, schools and registered training organisations are provided below. Further details about contact by the 36 young people with other State government departments and authorities is provided in the Appendix.

¹⁴¹ In this figure the acronyms refer to the following: **WA Health** WA Health (not including CAMHS, which is shown separately); **DCPFS** Department for Child Protection and Family Support; **Gov't. school** government schools; **WAPOL** Western Australia Police; **Housing** Department of Housing; **CAMHS** Child and Adolescent Mental Health Service; **DCS** Department of Corrective Services; **RTO** government and non-government registered training organisations; **DOTAG** Department of the Attorney General.

5.5.3.1 *Department for Child Protection and Family Support (DCPFS)*

Records indicate that, of the five young people in Group 4, four were known to DCPFS for a number of reasons:

- through a parent's application for financial assistance;
- through a Western Australia Police notification;
- through contact concerning advice regarding parent-adolescent conflict or wellbeing concerns about the young person's sibling.

5.5.3.2 *Schools and registered training organisations*

Records indicate that all of the five young people in Group 4 were enrolled with a government high school as their last school.

Four of the five young people in Group 4 had contact with a registered training organisation.

6 Strategic frameworks for preventing and reducing suicide by young people

6.1 Introduction

The research literature recognises that, because there is no simple explanation and no single solution for suicide, suicide prevention ‘requires concerted action on many fronts and a strategic framework to integrate these efforts’.¹⁴² This chapter provides an overview of the major strategic frameworks for suicide prevention that are in operation in Western Australia. These are the strategic frameworks that have been promoted at a national level by the Australian Government¹⁴³ and at a state level by the Western Australian Government.¹⁴⁴

These strategies aim to provide an overarching framework for the suicide prevention activities that are occurring at all levels in the community, to integrate existing activities into the framework, to identify where gaps exist and to stimulate additional activities by public, private and not-for-profit organisations to fill these gaps. The Office also analysed the extent to which the existing strategic frameworks correspond to the patterns in the factors associated with suicide identified during the investigation and discussed in Chapter 5.

6.2 Suicide prevention models

The research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 entitled *The spectrum of interventions for mental health problems and mental disorders (the Mrazek and Haggerty model)*.¹⁴⁵ This model continues to underpin current thinking about suicide prevention strategies. The Mrazek and Haggerty model divides interventions for mental health problems into three categories - Prevention, Treatment and Continuing Care – and further into eight domains associated with each of these categories (Figure 31).

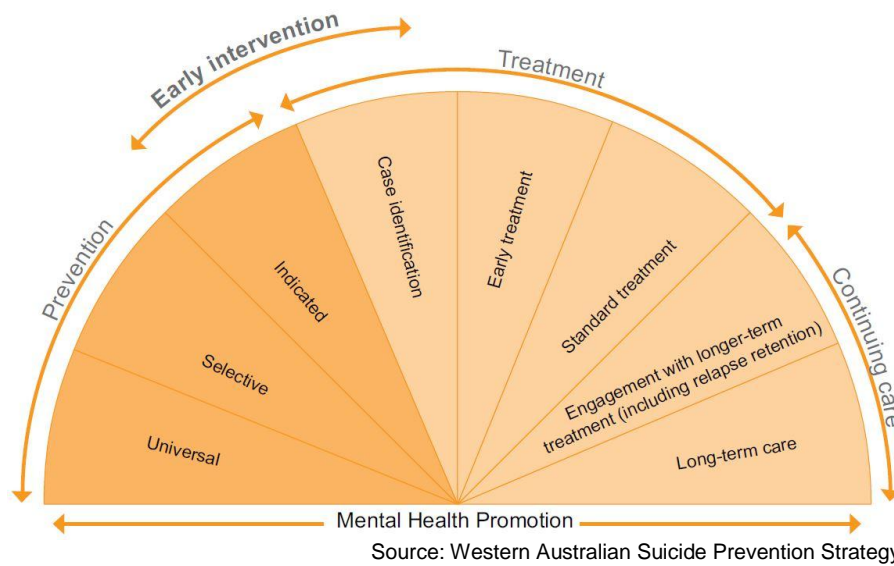
¹⁴² Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 30; Australian Government, Department of Health and Ageing, *National Suicide Prevention Strategy*, Australian Government Publishing Services, Canberra, 2012, p. 10.

¹⁴³ Australian Government, Department of Health and Ageing, *National Suicide Prevention Strategy*, Australian Government Publishing Services, Canberra, 2012; Australian Government, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Government Publishing Services, Canberra, 2013.

¹⁴⁴ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009.

¹⁴⁵ P Mrazek & R Haggerty (eds), *Reducing risks for mental disorders: frontiers for preventative intervention research*, National Academy Press, Washington, 1994.

Figure 31: Spectrum of interventions for mental health problems and mental disorders



More recent research recognises that ‘failures in complex systems tend to occur primarily at the points of handover of responsibilities’¹⁴⁶ and identifies the need to modify the Mrazek and Haggerty model to:

...respond to the need for support and care in the gaps between the model’s segments. Community-based safety nets are needed to bridge these gaps which focus on providing the support needed by people who are feeling suicidal and are in transition between stages of professional care and support.¹⁴⁷

Studies of suicide among Aboriginal young people have taken a slightly different approach, stating that preventing suicide by Aboriginal young people ‘should be the business of all agencies that deal with child and youth development and wellbeing.’¹⁴⁸ The complexity of the causes of suicide ‘requires a sustained, strategic and transparent program of investment in multiple service interventions, service coordination and ongoing research to build the evidence based on effective and practical ways to prevent the loss of life.’¹⁴⁹

Within each category of suicide prevention strategies, a range of State government departments and authorities, health professionals, private sector and non-government organisations are currently providing information, services and support to prevent or reduce the risk of young people taking their own life. As part of these efforts, Aboriginal and non-Aboriginal organisations are working with Aboriginal communities to prevent or reduce the risk of suicide among Aboriginal young people in particular.

¹⁴⁶ Australian Government, Department of Health, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2007, p. 26.

¹⁴⁷ Australian Government, Department of Health, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2007, p. 26.

¹⁴⁸ Menzies School of Health Research, *Suicide of Children and Youth in the NT 2006-2010*, Darwin, 2011, p. 41.

¹⁴⁹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 14.

6.3 National level strategic frameworks

6.3.1 The *National Suicide Prevention Strategy*

The *National Suicide Prevention Strategy (the National Strategy)* states that it provides 'the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention.'¹⁵⁰

A key component of the National Strategy is the Living Is For Everyone (LIFE) Framework (**the LIFE Framework**). The LIFE Framework's *Continuum of Suicide Prevention Activities* 'provides a summary of the range of types of suicide prevention activities and interventions that are essential for a whole of community response to reducing the rate of suicide in Australia.'¹⁵¹ In recognition of the recent research literature that identifies that community-based safety nets are needed to bridge the gaps between the segments of the Mrazek and Haggerty model, as discussed above, the LIFE Framework's *Continuum of Suicide Prevention Activities* now also includes the following specific features:

- recognition that people respond to, and cope with, life events differently and vary in their vulnerability and resilience. A person may move with no apparent warning from apparent good health directly into distress and a need for immediate specialised care; and
- community-based safety nets to support people as they move from one treatment setting to another.¹⁵²

Further, the LIFE Framework is 'based on the understanding that suicide prevention activities will do no harm; there will be community ownership and responsibility for action to prevent suicide; and service delivery will be client-centred.'¹⁵³ The LIFE Framework identifies the following six Action Areas:

- Action Area 1 - Improving the evidence base and understanding of suicide prevention;
- Action Area 2 - Building individual resilience and the capacity for self-help;
- Action Area 3 - Improving community strength, resilience and capacity in suicide prevention;
- Action Area 4 - Taking a coordinated approach to suicide prevention;
- Action Area 5 - Providing targeted suicide prevention activities; and
- Action Area 6 - Implementing standards and quality in suicide prevention.

¹⁵⁰ Australian Government, Department of Health, *National suicide prevention strategy*, October 2012, viewed 14 March 2014, <<https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps#com>>.

¹⁵¹ Australian Government, Department of Health and Ageing, *A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2008, p. 21.

¹⁵² Australian Government, Department of Health, *Living is for everyone, A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2007, p. 18.

¹⁵³ Australian Government, Department of Health and Ageing, *A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2008, p. 6.

6.3.2 The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*

In May 2013, the Australian Government Department of Health and Ageing released the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (the ATSI Strategy)*. This responds to the recommendation of the Senate Community Affairs References Committee in 2011 that ‘...the Commonwealth Government develop a separate suicide prevention strategy for indigenous communities within the *National Suicide Prevention Strategy*.’¹⁵⁴

The Foreword to the ATSI Strategy recognises that ‘suicide is a complex and multidimensional issue...This is even more so for Aboriginal and Torres Strait Islander peoples who are experiencing suicide within their communities at approximately twice the rate of the rest of the population.’

In common with the National Strategy, ‘the overarching objective of the [ATSI] Strategy is to reduce the cause, prevalence and impact of suicide on individuals, their families and communities.’

The ATSI Strategy identifies six Action Areas that align with the Action Areas in the National Strategy but are in a different order ‘to reflect the logic of engagement of Aboriginal and Torres Strait Islander communities and the priority that needs to be given to supporting community leadership and community action in suicide prevention.’¹⁵⁵

A critical factor for suicide prevention identified by the ATSI Strategy is that Indigenous communities that have strong cultural continuity have significantly lower rates of suicide among their young people:

...the association between Indigenous communities that have a strong ‘cultural continuity’ with significantly lower rates of suicide among their young people, in comparison to communities under cultural stress. In broad terms, cultural continuity refers to self-determination and cultural maintenance. It is thought that young people from a strong cultural background have a sense of their past and their traditions and are able to draw pride and identity from them.¹⁵⁶

The ATSI Strategy identifies the need for culturally competent services that provide culturally safe management and treatment based on Aboriginal peoples’ understanding of culture, family and connection to the land. An example of quality indicators for such services can be found in the *Operational Guidelines for Aboriginal and Torres Strait Islander Suicide Prevention Services*, as follows:

- provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their lives and to mitigate the reverberations from suicide in the client’s community;

¹⁵⁴ The Senate Community Affairs Reference Committee, *The Hidden Toll: Suicide in Australia*, The Senate Printing Unit, Canberra, 2010.

¹⁵⁵ Australian Government, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Australian Government Publishing Service, Canberra, 2013, pp. 26-45.

¹⁵⁶ Australian Government, National Mental Health Commission, *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*, NMHC, Sydney, 2013.

- be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety;
- establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations; and
- be based on Aboriginal and Torres Strait Islander peoples' definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.¹⁵⁷

6.4 State level strategic framework – the *Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business*

The *Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business (the State Strategy)*, also known as the *One Life Strategy*,¹⁵⁸ is based on the National Strategy and is designed to 'provide the foundational framework for the State government to coordinate and invest in suicide prevention strategies at all levels in the community.'¹⁵⁹ The State Strategy is designed to 'implement a comprehensive strategy with a particular emphasis on young people, young men, Aboriginal people and people who live in rural and regional Western Australia.'¹⁶⁰

The State Strategy identifies that the 'National Suicide Prevention Strategy: *Living Is For Everyone* (LIFE) offers a framework from which new suicide prevention initiatives will be developed and delivered in Western Australia.'¹⁶¹ It identifies six Action Areas that mirror those in the National Strategy.

The State government has committed \$13 million over the four years 2009-2013 to implement the State Strategy.¹⁶² On 7 August 2013, the Minister for Mental Health, Disability Services and Child Protection, the Honourable Helen Morton (**the Minister**), advised that funding for suicide prevention under the State Strategy would be available until December 2013.¹⁶³

The Minister is responsible for leading the State Strategy and 'has been mandated by Cabinet to ensure that all State government departments prioritise suicide prevention and participate in a coordinated response to the issue.'¹⁶⁴ The Minister has given responsibility

¹⁵⁷ Australian Government, National Mental Health Commission, *Targeted prevention in Aboriginal and Torres Strait Islander communities*, viewed 14 March 2014, <<http://www.mentalhealthcommission.gov.au/our-report-card/preventing-suicide/in-focus.aspx>>.

¹⁵⁸ Ministerial Council for Suicide Prevention, '*One Life Strategy*', Perth, 2008, viewed 26 November 2013, <www.onelifewa.com.au/one-life-strategy/>.

¹⁵⁹ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 8.

¹⁶⁰ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 4.

¹⁶¹ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 31.

¹⁶² Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 3.

¹⁶³ Western Australia, Legislative Council, Debates, pp. 2858d-2859a.

¹⁶⁴ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p 3.

for the implementation of the State Strategy to the Ministerial Council for Suicide Prevention (**the Ministerial Council**) which comprises 'suicide prevention experts, community, corporate and government organisations and people who have been impacted by suicide.'¹⁶⁵

The government funding associated with the State Strategy is the responsibility of the Mental Health Commission and the Commissioner for Mental Health is accountable through the Minister to Parliament for this funding. The Commissioner is also a member of the Ministerial Council.¹⁶⁶ In addition, the Mental Health Commission has responsibility for strategic policy, planning, purchasing and monitoring of mental health services generally in Western Australia.¹⁶⁷

On 16 June 2010, the (then) Minister, Dr Graham Jacobs, announced that Centrecare had been appointed as the preferred non-government organisation to implement the State Strategy.¹⁶⁸ Centrecare has responsibility for the day to day work of the Ministerial Council, the development of community awareness initiatives and the coordination of training, research and evaluation of suicide prevention strategies across Western Australia.

As a part of the implementation of the State Strategy, Centrecare has engaged Local Community Coordinators to support local communities in mapping existing suicide prevention activities and determine the need for future initiatives that will be documented in Community Action Plans.¹⁶⁹ As at 7 August 2013, there were 45 Community Action Plans in 255 locations across the state.¹⁷⁰

Centrecare has entered into a partnership arrangement with Edith Cowan University to conduct the research and evaluation components of the State Strategy as an independent entity.¹⁷¹ The Minister, stated on 7 August 2013: '[T]he evaluation results [by Edith Cowan University] will inform the direction of the strategy past 2013...the government made a clear statement that the suicide prevention strategy will continue...'¹⁷²

In addition, the Office of the Auditor General is undertaking a performance audit focusing on whether the State Strategy has been successful in delivering effective, sustainable action to reduce suicide.¹⁷³

¹⁶⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business*, 2009-2013, Department of Health, Perth, 2009, p. 3.

¹⁶⁶ Ministerial Council for Suicide Prevention, *One Life Strategy: The Western Australian Suicide Prevention Strategy is a call to action*, Perth, viewed 26 November 2013, <www.onelifewa.com.au/one-life-strategy/>.

¹⁶⁷ Government of Western Australia, Mental Health Commission, *Mental Health 2020: Making it personal and everybody's business. Reforming Western Australia's mental health system*, Mental Health Commission Perth, 2010, p. 5.

¹⁶⁸ Western Australia, Legislative Assembly, Debates, pp. 3895b-3895b.

¹⁶⁹ Centrecare, *Suicide Prevention*, Perth, 2014, viewed 26 September 2013, <<http://www.centrecare.com.au/counselling-support-services-2/metropolitan-services/suicide-prevention/>>.

¹⁷⁰ Western Australia, Legislative Council, Debates, 7 August 2013, p2858d-2859a; Western Australia, Legislative Assembly, Estimates Debates, 21 August 2013, pp. 395b-407a.

¹⁷¹ Centrecare, *Suicide Prevention*, Perth, 2014, viewed 26 September 2013, <<http://www.centrecare.com.au/counselling-support-services-2/metropolitan-services/suicide-prevention/>>.

¹⁷² Western Australia, Legislative Council, Debates, pp. 2858d-2859a.

¹⁷³ Office of the Auditor General, *Current Audits 2013, Perth, 2013*, viewed 17 March 2014, <<https://audit.wa.gov.au/work-in-progress/current-audits/#PASSSP>>.

6.5 Implications of the patterns identified by the investigation

6.5.1 Different suicide prevention activities may be relevant to each of the four groups of young people

The State Strategy recognises Mrazek and Haggerty's model as providing 'a useful way to conceptualise suicide prevention'.¹⁷⁴ The State Strategy contains a simplified version of the Mrazek and Haggerty model, including its three categories of suicide prevention - Prevention, Treatment and Continuing Care – and its eight domains. The State Strategy also discusses the types of actions that would be taken in each domain.¹⁷⁵ This way of understanding suicide prevention is shown in Figure 32 below.

¹⁷⁴ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p. 29.

¹⁷⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p. 30.

Figure 32: Categories and domains of suicide prevention activities

Domain	Activities associated with this domain
<i>Prevention Category</i>	
1.Universal Intervention	Activities that apply to everyone (whole populations) and result in reducing access to means of suicide, altering media coverage of suicide, providing community education about suicide prevention and creating stronger and more supportive families, schools and communities.
2.Selective Intervention	For communities and groups potentially at risk and result in building resilience, strength and capacity and an environment that promotes self-help and help-seeking and provides support.
3.Indicated Intervention	For individuals at high risk and result in building strength, resilience, local understanding, capacity and support; being alert to early signs of risk; and taking action to reduce problems and symptoms.
<i>Treatment Category</i>	
4.Symptom Identification	Activities that are appropriate when vulnerability and exposure to risk are high, which result in being alert to signs of high risk, adverse health effects and potential tipping points; and providing support and care.
5.Early Treatment	Activities for finding and accessing early care and support, which result in providing first point of professional contact; targeted and integrated support and care; and monitoring and ensuring access to further information and care.
6.Standard Treatment	Activities that are appropriate when specialised care is needed and result in providing integrated professional care to manage suicidal behaviours and improve wellbeing as a step in recovery.
<i>Continuing Care Category</i>	
7.Longer-term Treatment and Support	Activities for preparing for a positive future, providing ongoing integrated care to consolidate recovery and reduce the risk of adverse health effects.
8.Ongoing Care and Support	Activities for 'getting back into life'...building strength, resilience, and adaptation and coping skills, and an environment that supports self-help and help-seeking.

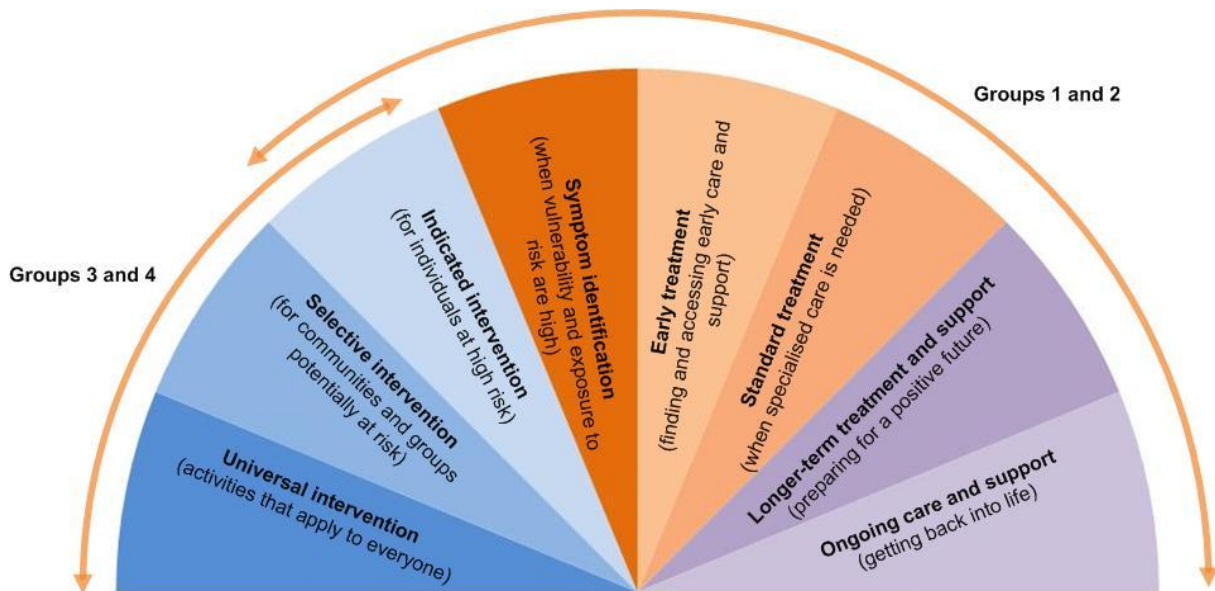
Source: LIFE Framework¹⁷⁶ and Ombudsman Western Australia

The Office's analysis in Chapter 5 indicates that the four groups of young people experienced different factors associated with suicide. The Office analysed how the patterns in the factors associated with suicide experienced by the 36 young people,

¹⁷⁶ Australian Government, Department of Health, *Living is for everyone, A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2007.

aligned with the categories and domains of suicide prevention activities. The Office's analysis found that each of the four groups may be aligned with different, albeit overlapping, domains of suicide prevention activities. This alignment is illustrated below.

Figure 33: Alignment between the patterns identified by the investigation and the domains for suicide prevention, as discussed in the LIFE framework



Source: LIFE Framework and Ombudsman Western Australia

Accordingly, different suicide prevention activities may be relevant to each of the four groups of young people, as follows:

- **Group 1** comprised 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, with most also recorded as experiencing mental health problems and suicidal ideation and behaviour. Suicide prevention activities that may be aligned with the characteristics of the young people in Group 1 involve recognising and addressing the impacts of child maltreatment and other mental health problems through: symptom identification; providing early, standard and/or longer term treatment; and providing ongoing care and support.
- **Group 2** comprised five young people who were recorded as either having been diagnosed with one or more mental illnesses, having a parent who had been diagnosed with a mental illness and/or demonstrating significant planning of their suicide. Suicide prevention activities that involve symptom identification and early, standard and longer term treatment of mental health problems may be aligned with the characteristics of the young people in Group 2, along with activities to provide ongoing care and support.
- **Group 3** comprised six young people who were recorded as having experienced few factors associated with suicide except for two young people who were recorded as having experienced suicidal ideation. These young people were recorded as being highly engaged in school and highly involved in sport. Universal, selective and indicated interventions, such as those already provided for under the State Strategy,

may be aligned with the characteristics of the young people in Group 3. However, it may also be important to consider whether research into suicide by young people who did not experience the currently identified factors associated with suicide, such as those young people in Group 3, should be conducted to develop a greater understanding of this group and inform future suicide prevention activities.

- **Group 4** comprised five young people who were recorded as having experienced few factors associated with suicide, except for four young people who were recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. However, the Office observed that all five young people were recorded as having demonstrated impulsive or risk taking behaviour. Universal interventions may be aligned with the characteristics of the young people in Group 4. In addition, three young people in Group 4 were Aboriginal, and three young people resided in a regional, remote or very remote area. Chapter 3 identified that Aboriginal young people are at significantly elevated risk of suicide, as are young people residing in a rural area. Accordingly, selective and indicated interventions, which target communities and individuals at risk, may also be aligned with the characteristics of the young people in Group 4.

Recommendation 1: As part of the development of the State Strategy past 2013, the Mental Health Commission considers developing differentiated strategies relevant to each of the four groups of young people, taking into account the findings of the investigation regarding the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities.

Recommendation 2: The Mental Health Commission, in collaboration with relevant stakeholders, considers whether it may be appropriate to undertake, or facilitate the undertaking of, mental health literacy and suicide prevention activities for those young people who demonstrate few factors associated with suicide, as identified by the investigation.

6.5.2 Preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child maltreatment and mental health problems

The State Strategy identifies that it is focused on the Prevention category of the Mrazek and Haggerty model, which comprises activities that ‘... can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.’¹⁷⁷ As shown in Figure 33 and discussed above, the Office’s analysis also indicates that suicide prevention activities in the Prevention category may be important and should continue. In addition, the Office’s analysis indicates that the factors

¹⁷⁷ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody’s business, 2009-2013*, Department of Health, Perth, 2009, p. 6.

associated with suicide experienced by 25 (69 per cent) of the 36 young people may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

6.5.3 State government departments and authorities potentially have an important role to play in preventing and reducing suicide by young people, including the Department of Health, the Department for Child Protection and Family Support and the Department of Education

The State Strategy identifies that State government departments and authorities have an important role to play in suicide prevention. The State Strategy recognises that:

Effective suicide prevention in Western Australia requires a coordinated approach across all levels of government and the whole of the community. It is important for all government agencies to deliver integrated policies, programs and responses to improve suicide prevention.¹⁷⁸

The Office's analysis, discussed in Chapter 5, is consistent with this. Records indicate that all of the 36 young people had contact with State government departments and authorities at some point in their lives. Thirty-one of the 36 young people (86 per cent) were recorded to have had contact with multiple State government departments and authorities. These 31 young people were across Groups 1 to 4.

Chapters 7 to 9 of this report contain detailed analysis of the contact by the 36 young people with three State government departments and authorities who potentially have an important role to play in addressing the factors associated with suicide identified by the Office's analysis. These are the Department of Health's Child and Adolescent Mental Health Service (**CAMHS**), the Department for Child Protection and Family Support (**DCPFS**) and the Department of Education. The recommendations in these sections are largely concerned with activities that align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model. The recommendations complement the State Strategy's existing focus on the Prevention category of the Mrazek and Haggerty model. The recommendations could be considered as part of the development of the State Strategy past 2013.

Although Chapters 7 to 9 discuss three of these departments separately it is not intended that these chapters are separable or that the departments work in isolation of each other. This point is discussed further in Chapter 10.

Recommendation 3: As part of the development of the State Strategy past 2013, the Mental Health Commission gives consideration to whether the scope of the State Strategy should be expanded to encompass the Treatment and Continuing Care categories of suicide prevention, by incorporating the investigation's recommendations about ways that State government departments can prevent or reduce suicide by young people.

¹⁷⁸ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p. 6.

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7 Ways of preventing and reducing suicide by young people by the Department of Health

7.1 Introduction

Chapter 4 identifies that a total of 12 (33 per cent) of the 36 young people were recorded as having been diagnosed with a mental illness. Eight of the 12 young people were recorded as having allegedly experienced at least one form of child maltreatment. These young people have been included in Group 1. In addition to child maltreatment, these eight young people were also recorded as having experienced many of the other factors associated with suicide, including self-harming behaviour, suicidal ideation and previous suicide attempts.

The remaining four young people who were recorded as having been diagnosed with a mental illness were also recorded as having demonstrated self-harming behaviour, suicidal ideation and previous suicide attempts. However, none of these four young people were recorded as having allegedly experienced child maltreatment or any adverse family experiences other than a parent with a mental illness. These young people have been included in Group 2.

The research literature identifies mental illness as a factor associated with suicide. The Child and Adolescent Mental Health Service (**CAMHS**), administered by the Department of Health, has a central role in providing assessments, case coordination and treatment services for children and adolescents under 18 years of age who have severe, complex and persistent mental illness. Services provided by CAMHS include:

- outpatient services provided in the community; and
- inpatient services (including at Princess Margaret Hospital and the Bentley Adolescent Unit).

CAMHS also provides specialist programs and services, including:

- intensive intervention programs for specific illnesses or circumstances including the Eating Disorders Program and the Family Pathways and Multi Systemic Program; and
- youth services including Youth Link and Youth Reach.¹⁷⁹

There are a number of ways a young person may be referred for assessment and potential treatment by CAMHS, the most usual being referral by a general practitioner or by a hospital emergency department. All of the 12 young people who were recorded as having been diagnosed with a mental illness were referred for assessment by CAMHS at some point in their lives. This contact presents an important opportunity to recognise and respond to mental illness and thereby to reduce the risk of suicide. This chapter examines referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for the 12 young people who were recorded as having been diagnosed with a mental illness.

¹⁷⁹ Government of Western Australia, Department of Health, Child and Adolescent Health Service, *About Child and Adolescent Mental Health Service*, 2013, viewed 26 September 2013, <<http://pmh.health.wa.gov.au/general/CAMHS/>>.

7.2 Legislative requirements applicable to mental health services

The primary piece of legislation setting out the requirements for the care, treatment, and protection of people who have a mental illness in Western Australia is the *Mental Health Act 1996* (the **Mental Health Act**). The objects of the Mental Health Act include:

- (a) to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity;
- (b) to ensure the proper protection of patients as well as the public; and
- (c) to minimize the adverse effects of mental illness on family life (section 5).

The Mental Health Act also defines the governing structure of mental health care in Western Australia, including the functions of the Minister for Health and the responsibilities of the Chief Psychiatrist. The functions of the Minister for Health include:

- (a) to promote the development and co-ordination of services for the care and treatment of persons who have mental illnesses; and
 - (b) to promote the integration of, and co-operation between, health and welfare services at State, regional, and local levels; and
 - (c) to encourage the development within the community of services emphasizing —
 - (i) the prevention of mental illness; and
 - (ii) the early detection and treatment of mental illness;
- and
- (d) to promote the development of voluntary and self-help groups and other community agencies for assisting persons who have mental illnesses and their families (section 8).

The responsibilities of the Chief Psychiatrist in relation to patients are:

- (1) The Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients.
- (2) In respect of other patients, the Chief Psychiatrist is required to monitor the standards of psychiatric care provided throughout the State (section 9).

7.3 Policies and standards for referrals, acceptance of referrals, risk assessments and discharge planning by mental health services

7.3.1 Priorities for acceptance of referrals by CAMHS

The *WA Country Health Service Child and Adolescent Mental Health Service Access Criteria Policy* sets out priorities for acceptance of referrals to CAMHS outpatient services (also referred to as 'intake'), for assessment upon intake and/or treatment, which states that young people are a priority for intake if they:

- have been discharged from an inpatient mental health unit;

- are likely to be diagnosed with a mental disorder;
- are at high risk due to the severity of their suicidal ideation, self-harming behaviour or present a risk of harm to others; and/or
- are exhibiting severe symptoms leading to substantial impairment of functioning. This could be in the context of family breakdown, delinquency, educational risk, vocational risk, school refusal and risk to peer relationships.¹⁸⁰

Policies applied in analysing the young peoples' acceptance of referrals to CAMHS were relevant at the time of referral. The Department of Health advises these policies have been subsequently updated.

7.3.2 Policies and standards for risk assessments and discharge planning

The Department of Health's policy entitled *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards (the CRAM Policy)* outlines a standardised approach that all WA Health mental health services are required to follow to manage clinical risk, thereby ensuring the proper protection of patients as well as the public. The policy defines three main risk areas:

- risk of harm to self (including self-harm and suicide);
- risk of harm to others (including violence and aggression); and
- risk of harm by others (physical, sexual or emotional harm or abuse by others).¹⁸¹

The CRAM policy applies to all hospitals and health services comprising WA Health, including CAMHS, mental health in-patient units and emergency departments of all hospitals.

The CRAM Policy also sets out requirements for risk assessments, and a corresponding risk management plan, once a decision has been made to accept a young person for intake and treatment (admission), as well as when a young person's circumstance changes. These requirements are as follows:

Clinicians [will] assess patients for risk on admission routinely, when their condition changes and before discharge. Informed by this assessment, clinicians [will] develop an individual risk management plan in collaboration with the patient (and family, where legal and where patient wishes allow).¹⁸²

In his 2012 review of admissions and discharge of mental health presentations at Fremantle Hospital, the Chief Psychiatrist identified that risk management plans should be reviewed when a person's condition changes, when they are transferred to other mental health services and on discharge from a mental health service, as follows:

¹⁸⁰ Government of Western Australia, Department of Health, *WA Country Health Service Child and Adolescent Mental Health Service Access Criteria Policy*, Perth, 2010, p. 2.

¹⁸¹ Government of Western Australia, Department of Health, *Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Service: Policy and Standards*, Department of Health, Perth, 2008, p. 8.

¹⁸² B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Department of Health & Mental Health Commission, Perth, 2012, p. 35.

It is preferable to use a standardised tool, such as the CRAM which includes the level of risk, formulation of risk and the risk management plan. The patient record should demonstrate adequate risk assessment in that risk has been reviewed at clinical review meetings, when discharged or transferred, if there is a change in the patient's status or when there are clinical concerns about risk.¹⁸³

The CRAM Policy acknowledges that not all clinical risk can be eliminated as suicide is a complex event, the risk factors vary with each individual and are changeable. Even over short periods of time:

...some degree of risk is inherent in the patient's lifestyle, the changing balance of provocative and suppressive factors for a suicide attempt and initial mental illness, in the nature of clinical care and of human performance in stressful conditions - but some risks are avoidable, some are remediable and the process of identifying, assessing and managing them will contribute to improving professional practice and the quality of healthcare provision.¹⁸⁴

The CRAM Policy also sets out requirements for the planning process when young people are discharged from mental health services. Discharge planning is to be a structured process for ensuring safe and successful transition of people with a mental illness across episodes of care from time of acceptance of referral to post-discharge. The *WA Suicide Prevention Strategy 2009–2013* recognises that:

A particularly high-risk time for suicide is after a person has been discharged from an inpatient mental health service. Therefore, careful discharge planning and continuity of care for people with mental health problems who are returning to the community is critical.¹⁸⁵

In addition to the CRAM Policy, all Western Australian mental health services, including CAMHS, are required to comply with the *National Mental Health Standards 2010 (the Standards)*.¹⁸⁶ The Standards require that:

Discharge planning results in a formal written discharge plan, the aim of which is to ensure continuity of services that are necessary for successful community living. The discharge plan is a negotiated enterprise between the consumer, carer or family, referring doctor, community mental health team and the inpatient unit. It includes medical information, follow-up appointments and the desired outcomes of treatment.¹⁸⁷

¹⁸³ Government of Western Australia, Department of Health, *Chief Psychiatrist's Review of Clinical Practice: Admissions and Discharges of Mental Health Presentations Fremantle Hospital*, Department of Health, Perth, 2012, p. 12.

¹⁸⁴ Government of Western Australia, Department of Health, *Chief Psychiatrist's Review of Clinical Practice: Admissions and Discharges of Mental Health Presentations Fremantle Hospital*, Department of Health, Perth, 2012, p. 3.

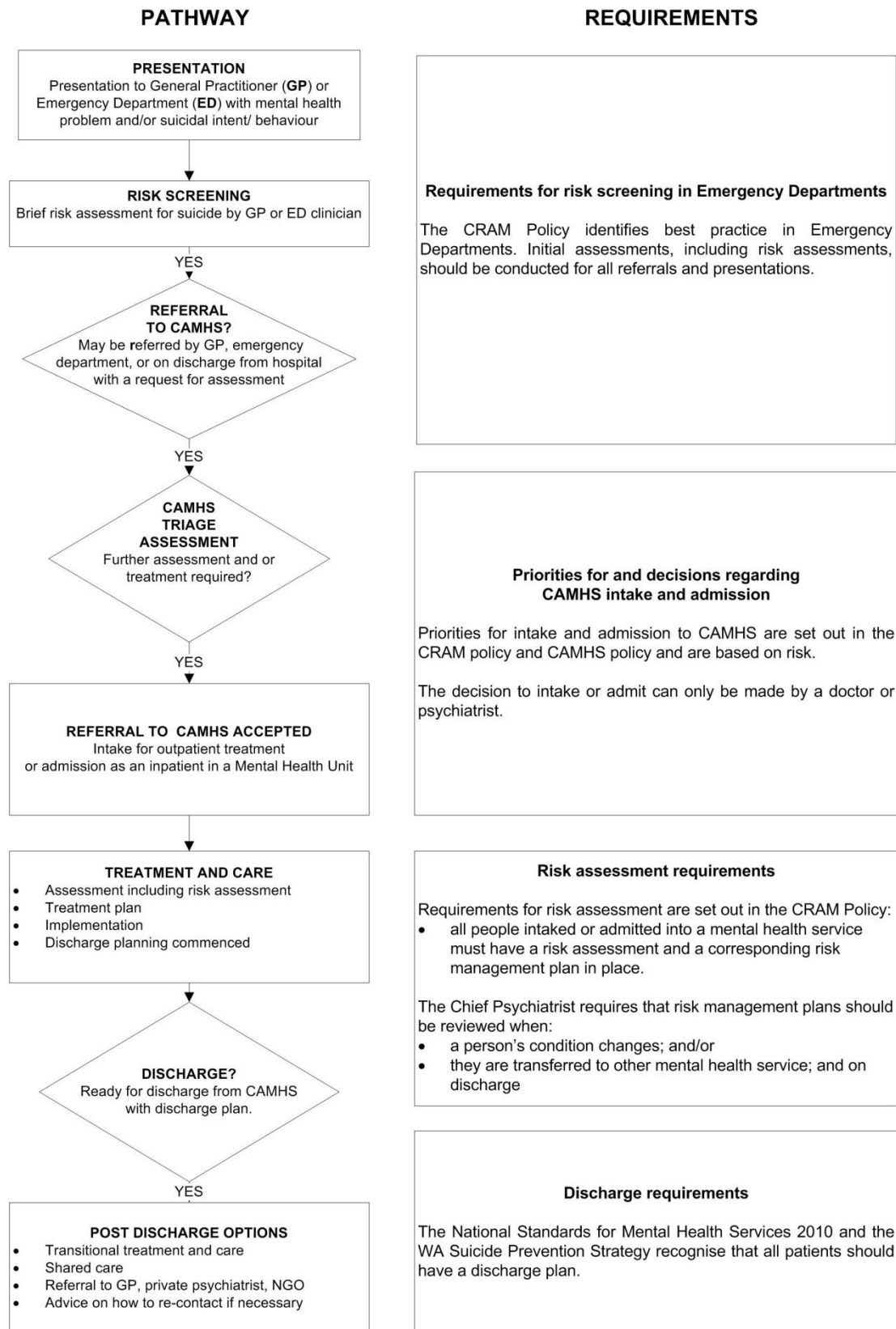
¹⁸⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 45.

¹⁸⁶ Government of Western Australia, Department of Health, *Chief Psychiatrist's Review of Clinical Practice: Admissions and discharges of mental health presentations Fremantle Hospital*, Department of Health, Perth, 2012, p. 8.

¹⁸⁷ Australian Government, Department of Health and Ageing, *National Standards for Mental Health Services 2010*, Commonwealth Government Printing Services, Canberra, 2010, p. 32.

The framework of legislation, policy and standards that set out the requirements for referral, acceptance of referrals, risk assessment, treatment and discharge planning of young people by mental health services, including CAMHS, is depicted in Figure 34 below.

Figure 34: Requirements for referral, acceptance of referrals by CAMHS, risk assessments and discharge planning



Source: Ombudsman Western Australia

7.4 Referral to and acceptance by the Child and Adolescent Mental Health Service for young people in Group 1

7.4.1 All eight young people in Group 1 who were recorded as having been diagnosed with a mental illness had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives

Of the 20 young people in Group 1, eight young people were recorded as having been diagnosed with a mental illness. Of these eight young people:

- all were referred to CAMHS at some time in their lives. Seven of these eight young people were referred to CAMHS services on more than one occasion, with a total of 36 referrals for the eight young people; and
- all were referred by either a general practitioner (22 referrals) or following attendance at a hospital emergency department (14 referrals).

The 36 referrals resulted in acceptance of the referral by CAMHS on 15 occasions, comprising nine instances of intake as an outpatient of CAMHS and six instances of admission to an inpatient unit of CAMHS. Two young people were referred but not accepted on referral to outpatient or inpatient units of CAMHS at any time in their lives.

7.4.2 During the last year of their lives, six of the eight young people were referred again but three young people were not accepted by CAMHS even though they met the priorities for acceptance

The policies regarding priorities for acceptance of referrals by CAMHS are set out in 7.3 above. Applying these priorities for acceptance of referrals, the Office found that all eight young people in Group 1 presented with at least two of the criteria for priority acceptance by CAMHS, as follows:

- four young people (50 per cent) were recorded as having been discharged from an inpatient mental health unit at some time in their life;
- five young people (62 per cent) were recorded as having been diagnosed with a mental illness and having been accepted and treated by an outpatient mental health service (now known as CAMHS) in the period preceding the last 12 months of their life;
- six young people (75 per cent) were recorded as having been at high risk due to self-harming behaviour and risk to self, that is, they were identified in health records as both self-harming and as having attempting suicide on at least one occasion; and
- eight young people (100 per cent) were recorded as exhibiting substantial impairment in functioning (as defined by the policies discussed in section 7.3.1). In particular:
 - all were recorded as having allegedly experienced multiple forms of child maltreatment including family and domestic violence, sexual abuse, physical abuse or neglect;
 - all were recorded as having experienced family breakdown;
 - four of the eight young people had contact with the Department of Corrective Services; and

- all were attending school less than 90 per cent of the time and therefore classified as being at educational risk (Figure 35).

Figure 35: Young people in Group 1 – priorities for acceptance by CAMHS

	Discharged from an inpatient mental health unit	Recorded as having been diagnosed with a mental illness	Recorded as having demonstrated self-harming behaviour	Recorded as having exhibited substantial impairment of functioning
Young person*				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person*				

*Note: these two young people were not referred to CAMHS during the last year of their lives
Source: Ombudsman Western Australia

Six of the eight young people had been referred to CAMHS in the year prior to their death. The remaining two young people had been discharged from CAMHS between two and three years prior to their death and were not referred to CAMHS again.

The six young people who were referred to CAMHS during the last year of their lives appeared to meet at least two of the priorities for acceptance on referral to CAMHS (as shown in Figure 35). Three young people were accepted on referral to CAMHS. The Office found that, in the last year of their lives, five of the six young people had not received services provided by CAMHS, as follows:

- two young people were on the waitlist for CAMHS or waiting for an initial appointment between two and five months before they died; and
- three young people who were referred to CAMHS in the year prior to their death either had the referral closed as attempts to contact them failed, they were referred to a specific CAMHS service but the referral was not pursued or the referral was not accepted.

Recommendation 4: The Department of Health considers the findings of this investigation in determining their state-wide provision of mental health services for young people.

Recommendation 5: The Department of Health ensures that the Child and Adolescent Mental Health Service applies the priorities for acceptance of referrals set out in its policies.

Recommendation 6: The Department of Health, where services are available, assists with the coordination of services from other government and non-government mental health services for young people who have been placed on a waitlist for services from the Child and Adolescent Mental Health Service.

Recommendation 7: Where a young person is referred to the Child and Adolescent Mental Health Service but not accepted by the Child and Adolescent Mental Health Service, the Department of Health notifies the referrer that the young person has not been accepted.

7.5 Referral to and acceptance by the Child and Adolescent Mental Health Service for young people in Group 2

7.5.1 Four young people in Group 2 were recorded as having been diagnosed with a mental illness and had been referred to CAMHS, and three of these young people received CAMHS services

Of the five young people in Group 2, four were recorded as having been diagnosed with a mental illness. These four young people were recorded as having been diagnosed with a mental illness during the last two years of their lives by a general practitioner and/or psychiatrist and were referred to CAMHS. These four young people had no prior history of mental health problems and had not previously been referred to CAMHS.

All of the four young people were accepted on referral by CAMHS and received CAMHS services or were waitlisted to receive services. Two of the young people receiving CAMHS services were admitted to an inpatient mental health unit of CAMHS.

The priorities for admission to CAMHS are set out at 7.3. Applying the priorities for admission, the Office found the four young people in Group 2 who were referred to CAMHS services experienced at least two of the criteria for admission, as follows:

- two (50 per cent) had been discharged from an in-patient mental health unit;
- four (100 per cent) were recorded as having demonstrated self-harming behaviour; and
- two (50 per cent) were recorded as having previously attempted suicide (Figure 36).

Figure 36: Young people in Group 2—priorities for acceptance by CAMHS

	Discharged from an inpatient mental health unit	Recorded as having been diagnosed with a mental illness	Recorded as having demonstrated self-harming behaviour	Recorded as having exhibited substantial impairment of functioning
Young person				
Young person				
Young person				
Young person				

Source: Ombudsman Western Australia

Of the four young people referred to and accepted by CAMHS, three young people were receiving out-patient services at the time of their death. These three young people received out-patient services on a weekly to fortnightly basis and were hospitalised when they attended emergency departments with suicidal ideation or behaviour or episodes of self-harm. The families of these young people were offered, and engaged in, family therapy.

7.6 Risk assessments for young people with a mental illness

The CRAM policy, discussed in section 7.3 and depicted in Figure 34, requires clinicians to undertake a risk assessment at several points: when a client presents to an emergency department with suicidal intent and/or behaviour; when a client is assessed for intake into an inpatient and outpatient mental health service; when a client is admitted to a mental health unit; when a client's condition changes; when the client is transferred from one mental health service to another; and when the client is discharged from a mental health service.

The CRAM policy was implemented in 2008. Accordingly, the Office reviewed risk assessments for young people presenting at an emergency department, referred to CAMHS, and admitted to a mental health unit, from 1 January 2009.

7.6.1 Risk assessments were not consistently undertaken for young people in Group 1

For the eight young people in Group 1 who had been diagnosed with a mental illness, the Office examined whether risk assessments were undertaken at three key points required by the CRAM policy. These points were: on presentation to an emergency department, on acceptance by CAMHS outpatient services and on admission to an inpatient mental health unit. The Office found that, for the eight young people in Group 1:

- risk assessments were not consistently undertaken at the three points where they were required by the CRAM policy; and
- risk assessments were more frequently undertaken on admission to an inpatient mental health unit (two risk assessments were undertaken on four admissions) than on

presentation to an emergency department with self-harm, suicidal ideation and/or behaviour (six risk assessments undertaken for 14 presentations).

7.6.2 Risk assessments were consistently undertaken for young people in Group 2

For the four young people in Group 2 who were recorded as having been diagnosed with a mental illness, the Office found that risk assessments were generally undertaken when the young people presented at emergency departments, were referred to CAMHS, and admitted to an inpatient mental health unit. The Office found that:

- risk assessments were frequently undertaken on presentation to an emergency department with self-harm, or suicidal ideation and behaviour (five risk assessments were undertaken for six presentations), on admission to an inpatient mental health unit (three risk assessments were undertaken on four admissions), on acceptance of referrals by CAMHS (three risk assessments were undertaken on five referrals); and
- the risk assessments undertaken by CAMHS included a psychosocial and biological component. All three young people for whom a risk assessment had been conducted also had a risk management plan in place.

Recommendation 8: The Department of Health ensures that risk assessments undertaken by the Child and Adolescent Mental Health Service are conducted in accordance with the Clinical Risk Assessment and Management policy and the findings of the Chief Psychiatrist, including for young people who present with a history of child maltreatment.

7.7 Discharge planning for young people who were recorded as having been diagnosed with a mental illness

As discussed above, discharge planning is critical in the successful transition of people with a mental illness across episodes of care, and all young people who have been discharged from CAMHS are required to have a discharge plan.¹⁸⁸

For the three young people in Groups 1 and 2 who had been inpatients of CAMHS, discharge planning had been conducted.

7.8 Aboriginal young people

As identified in Section 7.1, 12 of the 36 young people were recorded as having been diagnosed with a mental illness. Eight of the young people were included in Group 1 (these young people were all recorded as having allegedly experienced child maltreatment) and four young people were included in Group 2 (none of these young people were recorded as having allegedly experienced child maltreatment). Three of the eight young people included in Group 1 were Aboriginal and five were non-Aboriginal. All of the young people in Group 2 were non-Aboriginal.

¹⁸⁸ Australian Government, Department of Health, *National Standards for Mental Health Services 2010*, Australian Government Printing Services, Canberra, 2010, p. 32.

For the three Aboriginal young people who had been recorded as having been diagnosed with a mental illness, the Office found that:

- all three had been referred to CAMHS, and for two young people the referral had been accepted by CAMHS, at some point in their life;
- all had been referred to CAMHS on more than one occasion, with a total of 11 referrals for the three young people; and
- during the last year of their lives, two Aboriginal young people were referred again to CAMHS. Neither of these young people received services from CAMHS as a result of these referrals.

These findings are consistent with research literature which has described the limitations of mental health service delivery to Aboriginal young people in Western Australia as follows:

...While some comfort might be taken from the fact Aboriginal children and young people are receiving mental health services at all, the burden associated with their treatment and care is higher...When referrals are made there is frequently a much lower level of engagement and follow through with treatment than with non-Aboriginal children. This may reflect the current paucity of culturally sensitive mental health services for such children and families.¹⁸⁹

The research literature has shown the effectiveness of culturally appropriate mental health services successfully engaging Aboriginal young people.¹⁹⁰ This was also recognised in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, which recommended that government:

Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Services to assist Aboriginal people to access culturally secure Mental Health Services.¹⁹¹

The findings of this investigation support this recommendation.

7.9 Conclusion

Twelve of the 36 young people were recorded as having been diagnosed with a mental illness. However, these young people were recorded as having experienced different patterns among the other factors associated with suicide. For this reason, for the purposes of our analysis, eight of the young people were grouped into Group 1 (these young people were all recorded as having allegedly experienced child maltreatment) and four young

¹⁸⁹ S Zubrick, S Silburn, D Lawrence, F Mitrou, R Dalby, E Blair, J Griffin, H Milroy, J De Maio, A Cox & J Li, *The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal Children and Young People, Volume Two*, Curtin University and Telethon Institute for Child Health Research, Perth, 2005, pp. 574-575.

¹⁹⁰ Australian Institute of Health and Wellbeing, *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people*, Resource sheet No 19, 2013, viewed 24 February 2014, <<http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs19.pdf>>.

¹⁹¹ B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Department of Health & Mental Health Commission, Perth, 2012, p. 14.

people were grouped into Group 2 (none of these young people were recorded as having allegedly experienced child maltreatment).

The Office identified different patterns in referral, acceptance of referrals by CAMHS, and risk assessment between the two groups of young people. The young people in Group 1 appeared to meet similar priorities for acceptance by CAMHS as the young people in Group 2, however:

- while all eight of the young people who were recorded as having been diagnosed with a mental illness in Group 1 were referred to CAMHS services at some point in their lives, only six of these young people were referred again during the last year of their lives. Ultimately, five of the six young people had not received services provided by CAMHS in the last year of their lives;
- three of the four young people in Group 2 received CAMHS services upon their first referral, which occurred during the last two years of their lives. These three young people and their families received extensive services from CAMHS.

In addition, risk assessments were undertaken more consistently for young people in Group 2 than Group 1.

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8 Ways of preventing and reducing suicide by young people by the Department for Child Protection and Family Support

8.1 Introduction

Chapter 4 identifies that 20 of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. On the basis of this distinguishing factor, for the purposes of further analysis, these 20 young people have been grouped together and referred to as Group 1.

Child maltreatment, and its individual forms, has been identified in the research literature as a factor associated with suicide. An effective response to child maltreatment is therefore fundamental to reducing the risk of suicide by young people who have experienced this maltreatment.

The research literature also recognises that young people who have contact with child protection agencies have a significantly increased risk of suicide. For example, a New Zealand study found that:

Young people in contact with Child, Youth and Family are about 10 times more likely to kill themselves than New Zealand youth of the same age who have never had contact with the Department.¹⁹²

In Western Australia, the Department for Child Protection and Family Support (**DCPFS**) has a central role in protecting children and young people from maltreatment. Section 6 of the *Children and Community Services Act 2004* states:

The objects of this Act are –

...

(d) to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care

Chapter 5 identifies that all of the 20 young people in Group 1 had contact with DCPFS. This contact provides DCPFS with opportunities to assist in preventing and reducing youth suicide through its administration of the *Children and Community Services Act 2004*. This chapter discusses the opportunities that were identified through this investigation.

¹⁹² A Beautrais, P Ellis & D Smith, 'The risk of suicide among youth in contact with Child, Youth and Family', *Social Work Now*, no. 19, 2001, p. 9.

8.2 Child maltreatment and cumulative harm

8.2.1 The research literature identifies that different forms of child maltreatment often co-occur and their cumulative impact causes cumulative harm

The research literature finds that different forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse and neglect, often co-occur,¹⁹³ as stated below:

There is a growing body of evidence to show that maltreatment subtypes do not occur independently and that a significant proportion of maltreated individuals experience not just repeated episodes of one type of maltreatment, but are likely to be the victim of other forms of abuse or neglect.¹⁹⁴

The research literature also identifies that ‘as many forms of maltreatment co-occur and could have joint effects, their cumulative impact should not be overlooked.’¹⁹⁵ The effect of experiencing multiple forms of child maltreatment is referred to in the research literature as **cumulative harm**,¹⁹⁶ as follows:

Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or ‘layers’ of neglect. The unremitting daily impact on the child can be profound and exponential, covering multiple dimensions of the child’s life.

Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods.¹⁹⁷

The research literature observes that the way in which cumulative harm impacts on children ‘can be understood in terms of neurobiology (that is, brain development) and trauma (or psychological) theory.’¹⁹⁸ Numerous studies have found clear evidence that multiple episodes of child maltreatment adversely affect children’s brain structure and functioning.¹⁹⁹

¹⁹³ Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 25 February 2014, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.html>>.

¹⁹⁴ D Higgins, ‘Differentiating between child maltreatment experiences’, *Family Matters*, no. 69, 2004, p. 51.

¹⁹⁵ L Bromfield, P Gillingham & D Higgins, ‘Cumulative Harm and Chronic Child Maltreatment’, *Developing Practice: The Child, Youth and Family Work Journal*, no. 19, 2007 pp 34-42; R Miller, ‘Cumulative harm: a conceptual overview’, Victorian Government Department of Human Services, Melbourne, 2007, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf>.

¹⁹⁶ R Miller & L Bromfield, 2010, as quoted by R Price-Robertson, P Rush, L Wall & D Higgins, *Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma*, Australian Institute of Family Studies, Melbourne, 2013, p. 7.

¹⁹⁷ R Miller, *Cumulative harm: a conceptual overview*, Victorian Government Department of Human Services, Melbourne, 2007, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf>.

¹⁹⁸ L Bromfield, P Gillingham & D Higgins, ‘Cumulative Harm and Chronic Child Maltreatment’, *Developing Practice: The Child, Youth and Family Work Journal*, no. 19, 2007, pp. 34-42.

¹⁹⁹ J Belsky & M de Haan, ‘Annual Research Review: Parenting and children’s brain development: the end of the beginning’, *Journal of Child Psychology and Psychiatry*, vol. 52, no. 4, 2011, pp. 209-428.

Researchers investigating brain development use the term ‘toxic stress’ to describe the prolonged activation of stress management systems in the absence of support. Usually, stress causes a cascade of chemicals in the brain to ‘equip us to survive a stressful circumstance or event.’ However, prolonged stress ‘can disrupt the brain’s architecture and stress management systems’ and damage a child’s developing brain.²⁰⁰ Experienced early in life, toxic stress can ‘have a cumulative toll on learning capacity as well as physical and mental health.’²⁰¹

Other research literature identifies that exposure to ‘recurrent incidents of maltreatment over a prolonged period of time,’²⁰² or chronic trauma, can lead to developmental and psychological problems for children, including:

- disturbed attachment patterns;
- complex disruptions of emotional regulation;
- rapid behavioural regressions and shifts in emotional states;
- lack of self-motivation;
- aggressive behaviour against self and others;
- lack of awareness of danger, resulting in self-endangering behaviours; and
- self-hatred and self-blame and chronic feelings of ineffectiveness.²⁰³

Research into the impact of toxic stress and the psychological effects of chronic trauma has also been undertaken by the Australian Childhood Foundation, identifying the need for child protection to be ‘trauma informed’. This research identifies that:²⁰⁴

Left unrecognised and untreated, trauma related to abuse and family violence is cumulative in its impact. Multiple early victimisation significantly increases the likelihood of children and young people experiencing a range of negative emotional, psychological and behavioural manifestations which further restrain developmental resolution and identity formation.²⁰⁵

The same research also suggests that, ‘given appropriate parenting experiences, children can recover, or at least significantly improve’ after severe trauma caused by abuse and

²⁰⁰ L Bromfield, P Gillingham & D Higgins, ‘Cumulative Harm and Chronic Child Maltreatment’, *Developing Practice, The Child, Youth and Family Work Journal*, no. 19, 2007, pp. 34-42.

²⁰¹ J Shonkoff, *Investment in Early Childhood Development Lays the Foundation for a Prosperous and Sustainable Society*, Encyclopaedia of Early Childhood Development, Montreal, 2009, viewed 26 September 2013, <<http://www.child-encyclopedia.com/documents/ShonkoffANGxp.pdf>>.

²⁰² L Bromfield, P Gillingham & D Higgins, ‘Cumulative Harm and Chronic Child Maltreatment’, *Developing Practice: The Child, Youth and Family Work Journal*, no. 19, 2007, pp. 34-42.

²⁰³ R Price-Robertson, P Rush, L Wall & D Higgins, *Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma*, Australian Institute of Family Studies, Melbourne, 2013.

²⁰⁴ J Tucci, J Mitchell & C Goddard, *Response to the National Standards for Out of Home Care Consultation Paper*, Australian Childhood Foundation, Ringwood, 2010.

²⁰⁵ C Goddard & J Tucci, *Responding to child abuse and neglect in Australia*, Australian Childhood Foundation and Child Abuse Prevention Research Australia, Ringwood and Notting Hill, 2008, p. 13.

neglect.²⁰⁶ However, if this does not occur, over the longer term, child maltreatment can have 'a wide range of adverse consequences' for a child, which can last a lifetime.²⁰⁷ The research literature identifies a powerful relationship between child maltreatment and negative health outcomes throughout a person's life span including substance abuse, depressive disorders and attempted and successful suicide.²⁰⁸

The research literature also suggests that experiencing child maltreatment can result in broader, accumulative experiences of victimisation and harm. For example, children who have been maltreated may be more susceptible than others to peer violence or exposure to crime and children who were sexually abused may be more susceptible than others to re-victimisation.²⁰⁹

8.2.2 Seventeen of the 20 young people in Group 1 were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm

Of the 20 young people in Group 1, 17 (85 per cent) were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm. The pattern of child maltreatment among these 20 young people was as follows:

- three young people were recorded as having allegedly experienced one form of child maltreatment;
- ten young people were recorded as having allegedly experienced two forms of child maltreatment;
- five young people were recorded as having allegedly experienced three forms of child maltreatment; and
- two young people were recorded as having allegedly experienced all four forms of child maltreatment.

The different forms of child maltreatment that were recorded as having allegedly been experienced by the 20 young people in Group 1 are set out below Figure 37.

²⁰⁶ J Tucci, J Mitchell & C Goddard, *Response to the National Standards for Out of Home Care Consultation Paper*, Australian Childhood Foundation, Ringwood, 2010.

²⁰⁷ Australian Institute of Family Studies, *Effects of child abuse and neglect for adult survivors*, Australian Institute of Family Studies, Melbourne, 2010, viewed 26 September 2013, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.html>>.

²⁰⁸ S Dube, R Anda, V Felitti, D Chapman, D Williamson & W Giles, 'Childhood abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266, no. 24, 2001, p. 3094; Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 26 September 2013, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.html>>.

²⁰⁹ R Price-Robertson, P Rush, L Wall & D Higgins, *Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma*, Australian Institute of Family Studies, Melbourne, 2013, p. 2.

Figure 37: Different forms of child maltreatment that were recorded as having been allegedly experienced by the 20 young people in Group 1

	Family and domestic violence	Physical abuse	Sexual abuse	Neglect
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Young person				
Total	17	8	9	12

Source: Ombudsman Western Australia

In addition, of the 17 young people who were recorded as having allegedly experienced more than one form of child maltreatment:

- thirteen were recorded as having demonstrated suicidal ideation, with 12 having been recorded as having previously attempting suicide;

- eleven were recorded as having consumed alcohol at some time in their lives, and nine were recorded as having consumed illicit drugs;
- eight were recorded as having been diagnosed with a mental illness;
- eleven were recorded as having demonstrated self-harming behaviour; and
- ten were recorded as having a parent with a mental illness; eight were recorded as having a parent who demonstrated problematic alcohol or other drug use; five were recorded as having a parent who had been imprisoned; and six were recorded as having a family member, friend, or person known to them who had died by suicide.

8.3 Recognising cumulative harm when responding to child maltreatment

8.3.1 The research literature identifies that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments to recognise cumulative harm

The research literature identifies that in order to effectively identify and respond to cumulative harm, child protection and family services need to be holistic and well informed, conceptualising child maltreatment as ‘a chronic problem, rather than an isolated event in a child’s life.’²¹⁰ Considering child abuse, neglect or family and domestic violence as isolated events (or even a repeated series of such events), or dealing with such issues ‘episodically:’

[F]ails to acknowledge that some children’s development is characterised by repeated incidents of maltreatment over a prolonged time, and it fails to address the cumulative impact of repeated victimisation on children’s physical, psychological and developmental outcomes.²¹¹

Noting that it is a mistake to look at abuse or neglect as a point in time event, the research literature identifies the need for child protection to ‘go beyond immediate safety issues.’²¹² Practice and systemic barriers to recognising and responding to cumulative harm in this way that have been identified in the research literature include:

Practice risks:

- An event-oriented approach to Child Protection can result in practitioners failing to observe or be able to act in response to a pattern of maltreatment;
- Information is not carried over from one notification to the next and therefore information is lost over time;

²¹⁰ L Bromfield & D Higgins, ‘Chronic and isolated maltreatment in a child protection sample’, *Family Matters*, no. 70, 2005, p. 38.

²¹¹ L Bromfield & D Higgins, ‘Chronic and isolated maltreatment in a child protection sample’, *Family Matters*, no. 70, 2005, p. 38.

²¹² L Bromfield, P Gillingham & D Higgins, ‘Families who re-enter the child protection system, data from an Australian sample’, Conference Paper presented at the Ninth Australasian Conference on Child Abuse and Neglect, Sydney, November 2003.

- Assumptions are made that the problems presented in previous notifications are resolved at closure;
- Risk frameworks consider pattern and history with the aim of predicting future behaviour of carers and likelihood of harm rather than establishing the cumulative harm suffered; and
- IT systems [that] summarise and categorise previous contact and workloads in Child Protection are demanding therefore the assumption is made that reading case files is neither necessary nor a priority.

And systemic barriers:

- Child Protection being viewed and operated as an emergency service;
- The system not recognising that families' problems can be ongoing;
- Harm thresholds mean that children considered as 'low risk' fall outside the legislative mandate;
- A child has to be significantly harmed or at risk of significant harm; and the event is likely to happen again.²¹³

8.3.2 Legislation and policies in some other states and territories explicitly identify that child protection authorities need to undertake holistic assessments to recognise cumulative harm

In Victoria, legislation and policy incorporate specific provisions to identify and address cumulative harm. The Victorian *Children, Youth and Families Act 2005* provides a legislative mandate for the need to consider the potential for cumulative harm in child protection practice, identifying that, in determining what decision or action to take in the best interests of the child, consideration must be given to 'the effects of cumulative patterns of harm on a child's safety and development' (section 10(3)(e)). Section 162(2) of the *Children, Youth and Families Act 2005* further identifies that 'the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.'

Guidance on considering the potential for cumulative harm developed by the Victorian Department of Human Services, which is responsible for administering the *Children, Youth and Families Act 2005*, identifies that sections 10 and 162 of the legislation 'enable earlier intervention and prevention to promote development and safety, and recognition of the cumulative impact of acts, omissions or circumstances that may result in significant harm whereby a child is in need of protection.'²¹⁴

²¹³ L Bromfield, P Gillingham & D Higgins, 2003, quoted by R Miller, *Cumulative harm: a conceptual overview*, Victorian Government Department of Human Services, Melbourne, 2007, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf>.

²¹⁴ L Bromfield, P Gillingham & D Higgins, 2003, quoted by R Miller, *Cumulative harm: a conceptual overview*, Victorian Government, Department of Human Services, Melbourne, 2007, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf>.

In relation to considering the potential for cumulative harm, research findings adopted by the Victorian Department of Human Services identify the following multi-dimensional practice objectives:

- i) Early intervention (early in the development of the problem and early in the child's life).
- ii) Intervention as early as possible in the development of the problem in order to divert the trajectory of maladaptive development.
- iii) Creation of resilience factors and protective factors within a child's environment including family, school and community via connectedness and engagement to mitigate future risk and commence healing.²¹⁵

These research findings also identify that the prevalence of episodic assessment may be rationalised by the practicalities of resource constraints, ongoing demand, and the increasing complexity of issues present in families. It may also be conceptualised as a 'systemic adaptation that endeavoured to prioritise the most severe cases so that the system would not be overwhelmed by demand and rendered ineffectual.'²¹⁶

Practice resources created by the Victorian Department of Human Services identify that considering the potential for cumulative harm requires that practitioners assess each report or notification 'as bringing new information that needs to be carefully integrated into the history [of the child] and in a holistic assessment of the cumulative impact on the child, rather than an episodic focus on immediate harm.'²¹⁷

In efforts to move away from episodic responses to child maltreatment and towards holistic assessments, other Australian states and territories have incorporated the following responses to cumulative harm in their legislation and policy materials.²¹⁸

- **New South Wales** - the definition of significant harm, as outlined in the *New South Wales Mandatory Reporter Guide* of 2013, identifies that 'the significance can result from a single act or omission or an accumulation of these.' The *Protecting and Supporting Children and Young People Policy* of the Department for Education and Communities further identifies that Principals and workplace managers are responsible for reporting to the Child Wellbeing Unit about the safety, welfare and wellbeing of

²¹⁵ L Bromfield, P Gillingham & D Higgins, 2003, quoted by R Miller, *Cumulative harm: a conceptual overview*, Victorian Government, Department of Human Services, Melbourne, 2007, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf>.

²¹⁶ R Miller, *Cumulative harm: A conceptual overview*, Victorian Government, Department of Human Services, Melbourne, 2007, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf>.

²¹⁷ L Bromfield & R Miller, *Cumulative harm: Best interests case practice model – Specialist practice resource*, Victorian Government, Department of Human Services, Melbourne, 2012, viewed 26 September 2013, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/665902/cumulative-harm-specialist-practice-resource-2012.pdf>.

²¹⁸ L Bromfield, 'Recognising Cumulative Harm: Australian Child Protection Policy and Practice: Progress to date', paper presented at the Australasian Human Development Association Conference, Adelaide, 7 July 2009.

children and young people where ‘there is an observable pattern of cumulative harm that does not meet the threshold of significant harm.’²¹⁹

- **Tasmania** - in 2011, the Parliament of Tasmania’s Final Report of the Select Committee on Child Protection recommended that:

Legislation be amended to change the focus on episodic interventions to cumulative harm and new provisions introduced to enable child protection services to intervene with children who, over the long-term, have experienced cumulative trauma and harm.²²⁰

Specific information and guidance regarding cumulative harm is included in the Department of Health and Human Services 2012 *Family Support Services Operational Framework*, also supporting the view that ‘a focus on episodic assessment and immediate safety will not fully appreciate the cumulative harm experienced and its devastating impact on development.’²²¹

- **Australian Capital Territory** - the Office for Children, Youth and Family Support’s 2010 Practice Paper, ‘*Focus on Neglect*,’ identifies the cumulative nature of neglect, noting that ‘approaches to neglect need to move away from incidence-based intervention and assessment, toward assessment of cumulative harm, with intervention and support aimed at the long term.’ It further identifies that:

[T]o focus on singular incidences and respond episodically in times of crisis does not address the ongoing nature of the harm experienced in cases of neglect.²²²

- **Queensland** - specific guidance regarding cumulative harm is included in the Department of Communities, Child Safety and Disability Services’ *Practice Guide: The assessment of harm and risk of harm*. It further identifies the need to avoid episodic assessment, stating that, in assessing incidents, ‘a holistic approach is required, with harm being considered along a continuum – with any cumulative harm from past experiences together with current harms and future risks being considered.’²²³

²¹⁹ New South Wales Government, Department of Education and Communities, *Protecting and Supporting Children and Young People Policy*, Department of Education and Communities, Sydney, 2013, viewed 26 September 2013, <https://www.det.nsw.edu.au/policies/student_serv/child_protection/prot_children/PD20020067.shtml>.

²²⁰ Parliament of Tasmania, *Final Report, Select Committee on Child Protection*, Hobart, 2011, p. 191, viewed 26 September 2013, <<http://www.parliament.tas.gov.au/ctee/House/Reports/Final%20Report%20CP.pdf>>.

²²¹ Tasmanian Government, Department of Disability, Housing and Community Services, *Family Support Services Operational Framework*, Department of Disability, Housing and Community Services, Hobart, 2012, viewed 26 September 2013, <http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0019/120808/Family_Support_Services_Operational_Framework_v5_LR.pdf>.

²²² Australian Capital Territory Government, Department of Disability, Housing and Community Services, Office for Children, Youth and Family Support, *Practice Paper: Focus on Neglect*, Office for Children, Youth and Family Support, Canberra, 2010, p. 10, viewed 26 September 2013, <http://www.dhcs.act.gov.au/__data/assets/pdf_file/0008/165635/OCYFS_Neglect_Practice_Paper.pdf>.

²²³ Queensland Government, Department of Communities, Child Safety and Disability Services, *Practice Guide: the assessment of harm and risk of harm*, Department of Communities, Child Safety and Disability Services, Brisbane, 2013, viewed 26 September 2013, <<http://www.communities.qld.gov.au/resources/childsafety/practice-manual/pg-assess-risk-of-harm.pdf>>.

8.4 Western Australian legislative and policy framework for child protection, including recognition of cumulative harm

8.4.1 There are no explicit legislative requirements in Western Australia for undertaking holistic assessments to recognise cumulative harm

Administered primarily by DCPFS, the *Children and Community Services Act 2004* (**the CCS Act**) is the legislative basis for services provided to children, young people and families in Western Australia. The objects of the CCS Act set out in section 6 include:

- (a) to promote the wellbeing of children, other individuals, families and communities; and
- (b) to acknowledge the primary role of parents, families and communities in safeguarding and promoting the wellbeing of children; and
- (c) to encourage and support parents, families and communities in carrying out that role; and
- (d) to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care.

...

The CCS Act does not explicitly provide for recognising and responding to cumulative harm. Most relevantly, section 28(c) of the CCS Act identifies that a child is in need of protection if the child 'has suffered, or is likely to suffer, harm as a result of any one of the following:

- (i) physical abuse;
- (ii) sexual abuse;
- (iii) emotional abuse;
- (iv) psychological abuse;
- (v) neglect, and the child's parents have not protected, or are unlikely or unable to protect, the child from harm, or further harm.'

However, section 3 of the CCS Act defines 'harm' as 'harm to the child's physical, emotional, or psychological development.' This could be considered to encompass the concept of cumulative harm.

Recommendation 9: The Department for Child Protection and Family Support considers whether an amendment to the *Children and Community Services Act 2004* should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.

8.4.2 Some DCPFS policies for responding to child maltreatment address the need to undertake holistic assessments to recognise cumulative harm

DCPFS's *Policy on Neglect* explicitly identifies cumulative harm in its operational description of neglect, further stating that 'the short and long-term, as well as **cumulative effects** of neglect can be significant, whether there is intent by the parent to harm or not' (emphasis added).²²⁴ DCPFS's policy on neglect was informed by a 2008 report prepared by the Western Australian Child Death Review Committee, 'Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present' (**the Group Analysis Report**).

The Group Analysis Report found that:

There was ... a tendency for caseworkers to overemphasise small improvements often without sighting the children and there was a very worrying absence of any assessment of the potential harms being done to children. In large part this stemmed from a focus upon single incidents of neglect rather than the possible presence of cumulative harm ... Common themes arising from the analysis of the service system response can be summarised as:

- unresolved tension between child centred and family focused practice;
- a focus upon single incidents of neglect and the 'start again' syndrome;
- an over optimistic emphasis on small improvements leading to case closure;
- the absence of any direct assessment of the impact of neglect upon the child;
- inadequate risk assessment and management; and,
- inadequate case or safety planning.²²⁵

The Group Analysis Report went on to recommend:

That the review of Service Delivery Policy and Field Worker Guidelines include the development of a clear and specific procedure for undertaking a:

a) formal and documented child impact assessment of the risks associated with cumulative harm in cases where neglect is indicated – including a rigorous assessment of their current wellbeing and development as well as any associated risks to their continuing development.²²⁶

Two further elements of DCPFS's policy framework contain indirect references to cumulative harm.

²²⁴ Government of Western Australia, Department for Child Protection and Family Support, *Policy on neglect*, DCPFS, Perth, 2012, viewed 26 September 2013
<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Neglect-PolicyOnNeglect.pdf>>.

²²⁵ K Francis, T Hutchins, S Siggers & D Gray, *Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present*, National Drug Research Institute, Perth, 2008, pp. ix-x.

²²⁶ K Francis, T Hutchins, S Siggers & D Gray, *Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present*, National Drug Research Institute, Perth, 2008, p. 57.

Firstly, the *Signs of Safety Child Protection Practice Framework (the Signs of Safety framework)* sets out an overarching approach to assessing information that raises concerns about a child's wellbeing, which should be applied during all child protection activities.²²⁷ The Signs of Safety Framework incorporates a series of questions (such as 'what are we worried about?' and 'what's working well?') to be applied to the process of ongoing assessment to gather information, undertake analysis and reach a judgement at a point in time, as follows:²²⁸

The *Signs of Safety Assessment and Planning Protocol* maps the harm, danger, complicating factors, strengths, existing and required safety and safety judgment in situations where children are vulnerable or have been maltreatment. The *Signs of Safety Assessment and Planning Protocol* and the questioning processes and inquiring stance that underpins it, is designed to be the organising map for child protection intervention from case commencement to closure.²²⁹

In the context of Safety and Wellbeing Assessments, section 5.1 of DCPFS's Casework Practice Manual (**the Casework Practice Manual**) identifies that the Signs of Safety framework encourages child protection practitioners to 'assess the concern for (a) child's wellbeing and the parent's capacity to protect including past harm (what harm has occurred to the child/ren?).'²³⁰

Secondly, Standard 2 of *Better Care, Better Services – Standards for children and young people in protection and care* requires that:

The Department for Child Protection [now DCPFS] undertakes a holistic assessment of concerns relating to the protection and safety of children and young people and takes protective action where required.²³¹

The explicit or indirect recognition of cumulative harm discussed above has not been extended to other relevant elements of the DCPFS's policy framework, which are the *Family and Domestic Violence Policy*, and the *Policy on Child Sexual Abuse*.²³²

²²⁷ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual 'Signs of Safety – the Department's Child Protection Framework*, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/03SignsofSafety-TheDepartment'sChildProtectionFramework.aspx>>.

²²⁸ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual 'Signs of Safety – the Department's Child Protection Framework*, DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/03SignsofSafety-TheDepartment'sChildProtectionFramework.aspx>>.

²²⁹ Government of Western Australia, Department for Child Protection and Family Support, *The Signs of Safety Child Protection Practice Framework*, DCPFS, Perth, 2011, viewed 26 September 2011, <<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/SignsofSafetyFramework2011.pdf>>.

²³⁰ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual, '5.1 Safety and Wellbeing Assessment'*, DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/01SafetyandWellbeingAssessment.aspx>>.

²³¹ Government of Western Australia, Department for Child Protection and Family Support, *Better care, Better Services – Standards for children and young people in protection and care*, DCPFS, Perth, 2007, p. 5, viewed 26 September 2013, <<http://www.dcp.wa.gov.au/Resources/Documents/Standards%20Monitoring%20Unit/Better%20Care%20Better%20Services%20-%20booklet.pdf>>.

²³² Government of Western Australia, Department for Child Protection and Family Support, *Policy on Child Sexual Abuse and Family and Domestic Violence Policy 2012*, DCPFS, Perth, 2009 and 2012, viewed 26 September 2013, <<http://www.dcp.wa.gov.au/Resources/Pages/PoliciesandFrameworks.aspx>>.

The importance of recognising cumulative harm, and avoiding episodic and crisis oriented child protection and family support services, was also identified in the 2007 review of the former Department for Community Development (**DCD**, now DCPFS) by Prudence Ford (**the Ford Review**). The Ford Review identified a number of concerns regarding the intake and assessment process undertaken by DCD when it received information ‘about harm or risk of harm to a child or young person or when it receives a request for assistance.’ Concerns identified with the intake and assessment process included:

In some cases it was not “holistic” and did not put together all the information available to the Department. Information could be available from case records (e.g. a series of apparently one-off contacts with the Department over some years), from other staff (e.g. Aboriginal staff involved with the family or community, parenting services staff etc).

“In cases where the Department had significant and long term involvement, the Department’s responses have often been episodic and crisis oriented in nature...”

...In some cases there appeared to be an overly optimistic view [o]n the part of the Duty Officers as to the parents’ ability to ensure their children’s safety and an acceptance of parental assurances that they would make the changes necessary to do so.²³³

²³³ P Ford, *Review of the Department for Community Development: Review Report*, Perth, 2007, p. 62, viewed 26 September 2013.
<http://www.merredin.com/merredin/d/Residents/Your_Community/Government_Portal/Department_for_Child_Protection/Downloads/FXQZZ639L6QKMTE12KI2P3UA9UC4CZ/0A2UICTV6IL2OM3.pdf/DCDRPTFordReview2007.pdf>.

8.4.3 Some DCPFS procedures for responding to child maltreatment address the need to undertake holistic assessments so as to recognise cumulative harm

At Chapter 15.2, the Casework Practice Manual sets out guidance for responding to young people who express suicidal thoughts and behaviours and/or who are engaging in self harming behaviour. This guidance does not explicitly recognise multiple forms of child maltreatment, or the cumulative harm that may result, as a risk factor for suicide. It therefore does not necessarily require DCPFS to take child maltreatment into account when it is identifying and responding to the risk of suicide by young people.

DCPFS procedures for responding to information that raises concerns about a child's wellbeing are set out below. These procedures make one direct reference to recognising and responding to cumulative harm.

Stage 1 – Duty interaction

DCPFS may first become aware of an allegation of child maltreatment or signs of cumulative harm when a person, or 'referrer', contacts DCPFS to express concern about a child's wellbeing. These contacts and DCPFS's immediate responses to them comprise the 'duty interaction' process. Section 4.1 of the Casework Practice Manual) guides 'duty officers in deciding whether the Department has a role in promoting or safeguarding a child's wellbeing based on information received from a referrer',²³⁴ as follows:

Duty interaction

Duty interactions allow duty officers to assess the information they have received and ascertain what, if any, further information and assessment is needed, and whether the Department has an ongoing role with the child in relation to the child's safety, wellbeing and/or protection.

Duty officers can perform the following tasks during a duty interaction:

- 1 clarifying information with the referrer
- 2 checking Department records in Assist and Objective [DCPFS's electronic records and case management systems], and
- 3 contacting the person/s with parental responsibility.

Stage 2 – Intake and initial inquiries

Following a duty interaction, in a range of circumstances DCPFS can 'intake' a case and undertake 'initial inquiries', which are discussed in the Casework Practice Manual as follows:

²³⁴ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '4.1 Duty Interactions and Initial Inquiries', DCPFS, Perth, 2013, viewed 25 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

Initial inquiries

An intake is completed to undertake initial inquiries when the Department has determined it:

- may have a role based on the information received in relation to concerns for a child's wellbeing (includes the care, development, health and safety of the child), or
- there is concern about the parent's capacity to protect, and/or
- the duty officer needs to make inquiries about this child outside of the Department, the parent or referrer.

In addition, the *Practice Requirements for Duty Interactions and Initial Inquiries*, set out in the Casework Practice Manual, identify that:

Where a family presents on multiple occasions (including requests for financial assistance) within a short period of time, an assessment must be undertaken:

- access previous department records
- make further enquiries with other agencies, professionals, and
- engage directly with the family.

If an assessment is not undertaken, the rationale for the decision must be recorded and approved by the designated senior officer. At every subsequent contact by the family, the need to undertake an assessment must be reviewed. This decision and the rationale must be recorded and approved by the designated senior officer.

Section 4.6 of the Casework Practice Manual relating to neglect also states:

Determining if the current referral links to previous reports or assessments

At intake, the rationale for 'no further action' on previous report(s) needs to be re-considered, and a new analysis be developed, based on the information provided in the current report. Workers must take a **cumulative harm** perspective by re-examining previous reports in the context of the new report to assess whether a number of low-level risk factors combined are placing the child at risk of significant cumulative harm [emphasis added]...

Stage 3 – Safety and Wellbeing Assessment

Section 5.1 of the Casework Practice Manual identifies that, during the initial inquiries process, child protection workers may undertake a Safety and Wellbeing Assessment (**SWA**) 'to ascertain the current circumstances of a child and family in relation to risk,

harm, future danger, safety, wellbeing and protective concerns.²³⁵ The Casework Practice Manual relevantly provides:

The duty officer should move directly [from Initial Inquiries] to a Safety and Wellbeing Assessment, with team leader approval, where the Department has a clear ongoing role. Child Protection Workers should refer to Chapter 5: Safety and Wellbeing Framework ...

Decision to commence Safety and Wellbeing Assessment (SWA)

The decision to commence a SWA within twenty-four hours (priority 1) or 2-5 days (priority 2) is made at the conclusion of the initial inquiry stage and should be recorded at the initial inquiry decision date ...²³⁶

The purpose of a SWA is to clarify if:

1. the child has suffered significant harm, or is likely to suffer harm as a result of abuse and/or neglect
2. the child's parents have not protected or are unlikely or unable to protect the child from harm or further harm of that kind
3. a safety plan is required
4. the wellbeing concerns are likely to place the child at risk of significant harm in the future if joint work is not undertaken with the family.

Harm to the child is defined in s.3 of the [CCS] Act as 'harm, in relation to the child, includes harm to the child's physical, emotional and psychological development...'²³⁷

Section 5 of the Casework Practice Manual explicitly identifies that a Safety and Wellbeing Assessment should involve 'some or all' of a number of tasks, including 'assess[ing] for the presence or risk of **cumulative harm**' (emphasis added).²³⁸

At section 5.1, the Casework Practice Manual identifies that completion of a Safety and Wellbeing Assessment can result in actions being taken to protect and care for a child, which can include:

- no further action;
- the provision of social services (section 21(1)(a));

²³⁵ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

²³⁶ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '4.1 Duty Interactions and Initial Inquiries', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

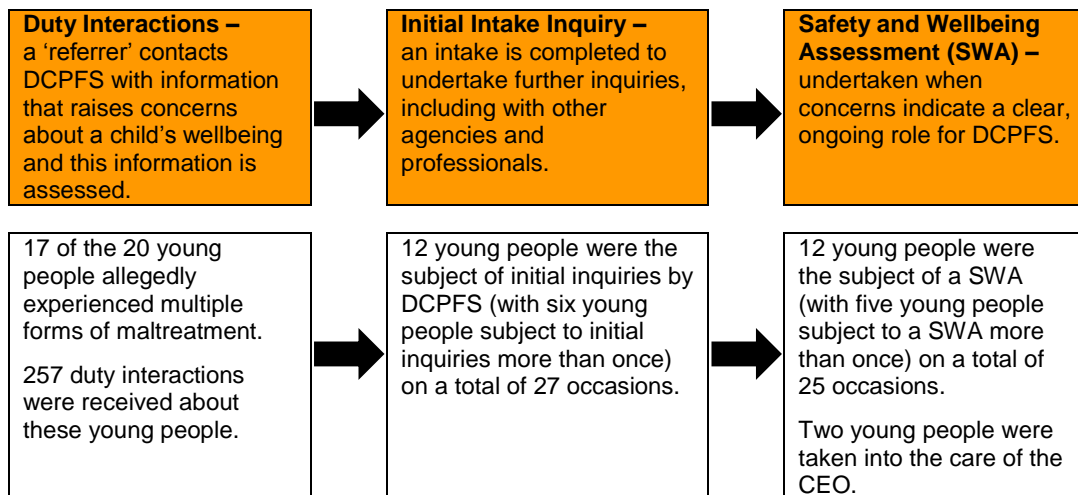
²³⁷ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

²³⁸ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

- the provision of child centred family support (section 32(1)(a));
- arranging or facilitating a meeting between key stakeholders to develop a plan for addressing the ongoing needs of the child (section 32(1)(b));
- entering into a negotiated placement agreement (section 32(1)(c));
- taking intervention action in respect of the child, or causing intervention action to be taken (section 32(1)(e)); and
- taking any other action in respect of the child that the Department considers reasonably necessary, or causing other actions to be taken (section 32(1)(f)).²³⁹

A summary of the DCPFS procedures for receiving and responding to information that raises concerns about a child's wellbeing is depicted below Figure 38.

Figure 38: Overview of DCPFS procedures, and summary of actions taken for the 20 young people in Group 1



Source: Ombudsman Western Australia

Recommendation 10: The Department for Child Protection and Family Support considers the revision of its relevant policies and procedures to recognise, consider and appropriately respond to cumulative harm that is caused by child maltreatment.

²³⁹ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

8.5 The Department for Child Protection and Family Support's assessment of the potential for cumulative harm to have occurred when responding to child maltreatment

Section 8.2.2 above identifies that, of the 20 young people in Group 1, 17 (85 per cent) were recorded as having allegedly experienced more than one form of child maltreatment. The research literature identifies that the co-occurrence of different forms of child maltreatment has a cumulative impact referred to as cumulative harm. The legislation and policies of some other Australian states and territories explicitly identify requirements for considering the potential for cumulative harm as part of responding to allegations of child maltreatment. Central to these requirements is the need to avoid an episodic approach to assessing and responding to information that raises concerns about a child's wellbeing, and instead take a holistic approach to these assessments.

Guided by the research literature, the legislation and policies of some other Australian states and territories, the CCS Act and DCPFS policies and procedures, the Office examined whether, for the 17 young people who were recorded as having allegedly experienced multiple forms of child maltreatment, DCPFS considered the potential for cumulative harm to have occurred by undertaking holistic assessments.

Section 8.4.3 identifies that the three key stages of DCPFS's procedures are:

- duty interactions;
- initial inquiries; and
- Safety and Wellbeing Assessments.

The Office examined the assessments undertaken by DCPFS staff at each of these three stages. As indicated, the Office examined only records held by DCPFS, and the evidence the records provided about the assessments made by DCPFS staff.

8.5.1 DCPFS received information that raised concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an assessment of this information

Of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, in total, DCPFS received information that raised concerns about the young person's wellbeing through 257 duty interactions (Figure 39).²⁴⁰

²⁴⁰ This included requests for financial assistance.

Figure 39: DCPFS procedures implemented for the 17 young people in Group 1 who were recorded as having allegedly experienced multiple forms of child maltreatment

Young person	Duty Interactions	Initial Inquiries*	Safety and Wellbeing Assessments or earlier equivalents**	Young person in the care of the CEO at some time in life
Young person	7	1	1	0
Young person	7	1	1	0
Young person	5	1	1	0
Young person	7	0	0	0
Young person	5	0	0	0
Young person	3	0	0	0
Young person	52	2	2	0
Young person	12	2	2	0
Young person	23	2	1	0
Young person	8	4	4	0
Young person	17	1	1	0
Young person	36	0	0	0
Young person	55	9	8	1
Young person	11	1	1	1
Young person	2	1	1	0
Young person	6	2	2	0
Young person	1	0	0	0
TOTAL	257	27	25	2

Source: Ombudsman Western Australia

*File records for 7 Initial Inquiries could not be found.

**File records for 10 Safety and Wellbeing Assessments could not be found.

As already identified, the Casework Practice Manual sets out that the duty interactions process allows duty officers ‘to assess the information they have received and ascertain whether the Department has an ongoing role with the child in relation to the child’s safety, wellbeing and/or protection.’ The Office identified that, of the 257 duty interactions during which DCPFS received information raising concerns about a young person’s wellbeing, there is documentation to indicate that DCPFS conducted an assessment of the information they received for 251 of these duty interactions.

8.5.2 It was not possible to examine whether DCPFS assessed the potential for cumulative harm during the duty interaction process

As already identified, in conducting duty interactions, the Casework Practice Manual identifies that duty officers can perform a range of tasks including:

1. clarifying information with the referrer
2. checking Department records in Assist and Objective [DCPFS's electronic records and case management systems], and
3. contacting the person/s with parental responsibility.

Checking the DCPFS records held in Assist and Objective to determine if DCPFS had previously received information raising concerns about the young person or their family would be the first step towards recognising the potential for cumulative harm by taking a holistic approach. For 16 (80 per cent) of the 20 young people in Group 1, DCPFS received information that raised concerns about the young person's wellbeing on multiple occasions (Figure 39). However, DCPFS does not record information which would enable the Office to determine whether, in conducting their assessment of information raising concerns about a young person, duty interactions staff checked the DCPFS records held in Assist and Objective to determine if DCPFS had previously received information raising concerns about the young person or their family.

Recommendation 11: The Department for Child Protection and Family Support enables and strengthens staff compliance with the policies and procedures that are applicable to the duty interaction process.

8.5.3 During 27 instances of intake and initial inquiries, DCPFS assessed the potential for cumulative harm, or progressed to a Safety and Wellbeing Assessment to enable this to be done, on 17 occasions.

Of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, DCPFS completed intake enabling initial inquiries to be undertaken for 12 (71 per cent) young people in a total of 27 instances, (Figure 39). As already identified, the Casework Practice Manual identifies that:

Where a family presents on multiple occasions (including requests for financial assistance) within a short period of time, an assessment must be undertaken:

- access previous department records
- make further enquiries with other agencies, professionals, and
- engage directly with the family.

For these 12 young people, the Office examined whether, during the initial inquiries process, DCPFS considered the potential for cumulative harm to have occurred. The Office examined this by identifying whether there was evidence that DCPFS:

- (i) acknowledged other information already held by DCPFS about the young person and their family;
- (ii) took into account other information about the young person and their family obtained during the course of intake/initial inquiries or Safety and Wellbeing Assessments:
 - from the person raising the concern;
 - from a staff member of another State government department or authority;
 - from a staff member of a non-government organisation;
 - from the young person or their family; and
- (iii) used the information obtained through (i) and (ii) for the purpose of assessing for cumulative harm.

The Office was able to find records relating to 19 of the 27 intake and initial inquiries procedures. The Office identified that:

- there was evidence to indicate that DCPFS acknowledged other information already held by DCPFS about the young person and their family in 12 instances (**Criteria i**);
- there was evidence to indicate that DCPFS took into account other information about the young person and their family obtained during the course of intake or initial inquiries in 15 instances (**Criteria ii**);
- in 17 instances, DCPFS moved directly from initial inquiries to a Safety and Wellbeing Assessment (discussed further below); and
- in the two instances where initial inquiries did not progress to a Safety and Wellbeing Assessment, there was no evidence to indicate that DCPFS used the information obtained through (i) and (ii) for the purpose of assessing for cumulative harm (**Criteria iii**) (Figure 40).

Figure 40: Summary of examination of records of intake and initial inquiries for assessment of the potential for cumulative harm

Young person	Allegation	Criteria (i)	Criteria (ii)	Criteria (iii)
Young person	Sexual harm	N/A*	Yes	Progress to SWA
Young person	Neglect	Yes	Yes	Progress to SWA
Young person	Sexual harm	Yes	Yes	Progress to SWA
Young person	Family and Domestic Violence	No evidence	Yes	Progress to SWA
	Physical harm	No evidence	Yes	Progress to SWA
Young person	Physical harm	Yes	No evidence	Progress to SWA
	Physical harm	Yes	Yes	Progress to SWA
Young person	Physical harm	Yes	Yes	Progress to SWA
	Neglect	No evidence	No evidence	No evidence
Young person	Sexual harm	Yes	Yes	Progress to SWA**
	Physical harm	Yes	Yes	Progress to SWA**
	Physical harm	Yes	Yes	Progress to SWA
	Physical harm	No evidence	Yes	Progress to SWA
Young person	Neglect	Yes	Yes	Progress to SWA
Young person	Sexual harm	Yes	Yes	No evidence
	Physical harm	Yes	Yes	Progress to SWA
	Physical harm		Documents not found	
	Sexual harm		Progress to SWA no intake	
	Sexual harm		Documents not found	
	Neglect		Documents not found	
	Physical harm		Documents not found	
	Physical harm		Documents not found	
Young person	Neglect		Documents not found	
Young person	Sexual harm	Yes	No evidence	Progress to SWA
Young person	Sexual harm	No evidence	Yes	Progress to SWA
	Sexual harm		Documents not found	

Source: Ombudsman Western Australia

*No previous records held by DCPFS concerning this young person. Cumulative harm criteria (i) not applicable.

** Documents were not found for these SWAs.

8.5.4 As part of 25 Safety and Wellbeing Assessments DCPFS assessed the potential for cumulative harm in two Safety and Wellbeing Assessments, or earlier procedural equivalents

Of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, DCPFS undertook a Safety and Wellbeing

Assessment, or an earlier procedural equivalent, for 12 young people in a total of 25 instances (Figure 41). As already identified, 'the purpose of a SWA [Safety and Wellbeing Assessment] is to clarify if: ... the child has suffered significant harm, or is likely to suffer harm as a result of abuse and/or neglect.'²⁴¹ Harm to the child is defined in s.3 of the [CCS] Act as 'harm, in relation to the child, includes harm to the child's physical, emotional and psychological development.'²⁴² In addition, section 5 of the Casework Practice Manual identifies that a Safety and Wellbeing Assessment should involve 'some or all' of a number of tasks, including to 'assess for the presence or risk of cumulative harm' when undertaking Safety and Wellbeing Assessments.²⁴³

The Office examined each of the Safety and Wellbeing Assessments to determine whether they considered the potential for cumulative harm to have occurred. The Office did this by examining whether there was evidence that DCPFS:

- (i) acknowledged other information already held by DCPFS about the young person and their family;
- (ii) took into account other information about the young person and their family obtained during the course of intake or initial inquiries or Safety and Wellbeing Assessments:
 - from the person raising the concern;
 - from a staff member of another State government department and or authority,
 - from a staff member of a non-government organisation;
 - from the young person or their family; and
- (iii) used the information obtained through (i) and (ii) for the purpose of assessing for cumulative harm.

The Office was able to find records relating to 15 of the 25 Safety and Wellbeing Assessments. The Office identified that:

- there was evidence to indicate that DCPFS acknowledged other information already held by DCPFS about the young person and their family in eight instances (**Criteria i**);
- there was evidence to indicate that DCPFS took into account other information about the young person and their family obtained during the course of intake/initial inquiries or SWA in 12 instances (**Criteria ii**); and

²⁴¹ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

²⁴² Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

²⁴³ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '5.1 Safety and Wellbeing Assessment', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

- there was evidence to indicate that DCPFS used this information obtained through (i) and (ii) for the purpose of assessing for cumulative harm in two instances (**Criteria iii**) (Figure 41).

Figure 41: Summary of examination of Safety and Wellbeing Assessments (or earlier equivalents) for assessment of the potential for cumulative harm

Young person	Allegation	Criteria (i)	Criteria (ii)	Criteria (iii)
Young person	Sexual harm	Yes	Yes	N/A
Young person	Neglect	Yes	Yes	No evidence
Young person	Sexual harm	Yes	Yes	No evidence
Young person	Family and Domestic Violence	No evidence	Yes	No evidence
	Physical harm	No evidence	Yes	No evidence
Young person	Physical harm	No evidence	No evidence	No evidence
	Physical harm	Yes	Yes	No evidence
Young person	Physical harm	Yes	Yes	No evidence
Young person	Sexual harm	Documents not found		
	Physical harm	Documents not found		
	Physical harm	Yes	Yes	Yes
	Physical harm	No evidence	Yes	No evidence
Young person	Neglect	Yes	Yes	No evidence
Young person	Physical harm	No evidence	No evidence	No evidence
	Physical harm	Documents not found		
	Sexual harm	No evidence	Yes	No evidence
	Sexual harm	Documents not found		
	Neglect	Documents not found		
	Physical harm	Documents not found		
	Physical harm	Documents not found		
Young person	Neglect	Documents not found		
Young person	Sexual harm	Yes	No evidence	No evidence
Young person	Sexual harm	No evidence	Yes	Yes
	Sexual harm	Documents not found		

Source: Ombudsman Western Australia

Further, of the 12 young people for whom DCPFS conducted a Safety and Wellbeing Assessment, after the conclusion of their final Safety and Wellbeing Assessment, DCPFS received further information that raised concerns about the wellbeing of ten young people. A total of 76 duty interactions were conducted following the completion of final Safety and Wellbeing Assessments for these ten young people.

None of these ten young people was the subject of further intake or Safety and Wellbeing Assessment by DCPFS.

Recommendation 12: The Department for Child Protection and Family Support enables and strengthens staff compliance with any revised policies and procedures which require them to assess the potential for cumulative harm to have occurred as a result of child maltreatment.

8.5.5 Aboriginal young people

Of relevance to this investigation, Aboriginal young people were the subject of higher levels of contact and involvement with DCPFS.

- Of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, nine were Aboriginal and eight were non-Aboriginal;
- Figure 39 identifies that DCPFS received 257 duty interactions about the 17 young people; 198 (77 per cent) of these duty interactions concerned Aboriginal young people; and
- Of the 12 young people who were the subject of initial inquiries or a Safety and Wellbeing Assessment, seven were Aboriginal and five were non-Aboriginal.

DCPFS currently engages, as a specialist position, Aboriginal Practice Leaders to assist with matters relating to Aboriginal young people. More specifically:

The Aboriginal practice leader is responsible for leading consistent high standards of services to Aboriginal children by contributing to the development and implementation of effective practices relating to Aboriginal children and their families.

The Case Work Practice Manual sets out specific requirements when the Aboriginal Practice Leader should be consulted. However, this requirement for consultation is generally limited to interactions involving children in the care of the Chief Executive Officer. For example, section 15.2 *Responding to Suicide and Self harm* requires:

The Aboriginal practice leader should be consulted about Aboriginal children in the CEOs care attending funeral or Sorry events relating to suicide, in order to explore balancing child safety with cultural considerations. Whilst funeral and Sorry events are important culturally and spiritually, there may be high levels of AOD misuse, grief, and attention on the person who has passed away. The Aboriginal practice leader will be able to advise on spiritual, cultural and practical issues relating to these events.²⁴⁴

The findings of this investigation indicate that it is also important that Aboriginal Practice Leaders are consulted when the potential for cumulative harm is being assessed for Aboriginal young people, to ensure responses to this harm are culturally appropriate.

²⁴⁴ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, '15.2 Responding to Suicide and Self-harm', DCPFS, Perth, 2013, viewed 26 September 2013, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/default.aspx>>.

Recommendation 13: In considering revisions to its policies and procedures to recognise cumulative harm, the Department for Child Protection and Family Support considers incorporating requirements to consult with Aboriginal Practice Leaders when the potential for cumulative harm is being assessed for Aboriginal young people.

8.5.6 Conclusion

Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Seventeen (85 per cent) of the 20 young people were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm. All of these 17 young people were known to DCPFS, many through multiple interactions. These interactions presented DCPFS with opportunities to identify and respond to child maltreatment and cumulative harm and thereby assist in preventing or reducing youth suicide. The Office found that:

- for the 17 young people who were recorded as having allegedly experienced more than one form of maltreatment, DCPFS received information that raised concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an initial assessment of this information;
- it was not possible for the Office to examine whether DCPFS assessed the potential for cumulative harm during the duty interaction process as information which would allow the Office to examine this is not recorded by DCPFS;
- for 12 young people there were 27 instances of intake and initial inquiries. During these initial inquiries there is evidence that DCPFS assessed the potential for cumulative harm, or progressed to a Safety and Wellbeing Assessment to enable this to be done, on 17 occasions. DCPFS did not progress to a Safety and Wellbeing Assessment in two instances. In these two instances, there is no evidence that DCPFS assessed the potential for cumulative harm;
- as part of 25 Safety and Wellbeing Assessments, there is evidence that DCPFS assessed the potential for cumulative harm in two Safety and Wellbeing Assessments.

Recognising and responding to cumulative harm more consistently would involve making more explicit, and expanding, DCPFS's policy framework, supported by practice resources to assist in implementation, such as DCPFS has already done with respect to its *Policy on Neglect* and associated sections of the Casework Practice Manual. This work could be informed by policies and practice resources already implemented in some other states and territories. To support these changes, DCPFS could also consider seeking an amendment to the CCS Act to make explicit reference to cumulative harm.

Recommendation 14: The Department for Child Protection and Family Support uses information developed about young people who are likely to have experienced cumulative harm as a result of child maltreatment to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.

9 Ways of preventing and reducing suicide by young people by the Department of Education

9.1 Introduction

The research literature identifies that educational institutions have an important role to play in reducing the incidence of suicide by young people as education professionals are in a unique position to identify and prevent the suicide of young people.²⁴⁵ Important indicators of mood such as academic performance, behaviour, interpersonal relationships and the ability to cope, are all subject to continual observation in the educational setting.²⁴⁶ A study has also associated failure or drop-out of school by young people with parent-child conflict and stressors related to family functioning, which in turn are highly predictive of suicide risk for this population.²⁴⁷

The research literature further identifies that educational institutions are particularly important for children and young people from certain groups, including young people who have experienced child maltreatment, resulting in cumulative harm, and Aboriginal young people. Children and young people with a history of child maltreatment may have difficulties in learning and interacting in socially appropriate ways.²⁴⁸ Early trauma reduces the capacity to regulate strong emotions, often resulting in conflict with students and teachers.²⁴⁹

All of the 20 young people in Group 1 were recorded as having allegedly experienced child maltreatment. These 20 young people also had contact with schools, 18 at government schools and two at non-government schools. This contact presents opportunities for government schools, in particular, to provide the protective factors that will assist in reducing the risk of suicide by these young people as they are in the process of being identified, referred for treatment by and after discharge from mental health services, as discussed in Chapters 7 and 8.

With respect to Aboriginal students, a Northern Territory submission to a Parliamentary Committee identified that 'it should not be assumed that lower school retention and achievement levels and lower expectations in some communities about academic success necessarily reduces the significance of school drop-out and related conflict with families, and the lack of support through this transition as a potential source of suicide risk.'²⁵⁰ Non-attendance at school among Aboriginal students has been recognised as a major

²⁴⁵ S Crawford & N Caltabiano, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education*, vol. 34, no 23, 2009, p. 29.

²⁴⁶ S Crawford & N Caltabiano, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education*, vol. 34, no 23, 2009, p.9.

²⁴⁷ B Randell, J Herting & L Eggert, 'Family Factors Predicting Categories of Suicide Risk', *Journal of Child & Family Studies*, vol. 15, no. 3, 2006, pp. 247-62.

²⁴⁸ T Beauchamp, *Addressing high rates of school suspension*, UnitingCare, Parramatta, 2012.

²⁴⁹ T Beauchamp, *Addressing high rates of school suspension*, UnitingCare, Parramatta, 2012.

²⁵⁰ G Robinson, S Silburn & B Leckning, *Submission to the Legislative Assembly of the Northern Territory Select Committee on Youth Suicide in the NT*, 2011, viewed 26 September 2013, <<http://www.nt.gov.au/lant/parliamentary/business/committees/ctc/youth-suicides/Submissions.shtml>>.

problem in Western Australia with poor attendance at school identified as one of the major factors driving Aboriginal disadvantage.²⁵¹

Informed by the findings of the research literature, the Office examined schooling for the young people in Group 1 who died by suicide from three perspectives:

- enrolment at school;
- attendance at school; and
- behaviour at school.

The Office also examined each of these perspectives on education for Aboriginal young people specifically.

The Department of Education is responsible for administering the *School Education Act 1999* (except Part 4 and other provisions as far as they apply to non-government schools). Eighteen of the 20 young people in Group 1 had contact with government schools. This contact presents the Department of Education with ongoing opportunities to assist in preventing and reducing youth suicide.

9.2 Enrolment in education and training

9.2.1 Legislative requirements

The *School Education Act 1999* provides the legislative framework for the operations of government schools, non-government schools and home education. The objects of the *School Education Act 1999* are provided in Section 3(1) and include:

- (a) to recognize the right of every child in the State to receive a school education; and
- (b) to allow that education to be given in a government school, a non-government school or at home; and
- (c) to provide for government schools that meet the educational needs of all children; and
 - (ca) to provide for education, training and employment alternatives at the senior secondary level; and
- (d) to acknowledge the importance of the involvement and participation of a child's parents in the child's education.

It is compulsory for children and young people to be enrolled in an educational program until they reach the age of 17 years. Section 9(1) of the *School Education Act 1999* provides:

A child is to be enrolled in an educational programme for each year of the compulsory education period for that child.

²⁵¹ S Zubrick, S Silburn & J Maio, *Western Australian Aboriginal Health Survey: Improving the educational experiences of Aboriginal children and young people*, Telethon Institute for Child Health Research, Perth, 2006.

For the period relevant to the investigation, section 6(1) of the *School Education Act 1999* provides:

- (1) The compulsory education period for a child is as follows —
 - (a) until 31 December 2012 —
 - (i) from the beginning of the year in which the child reaches the age of 6 years and 6 months; and
 - (ii) until the end of the year in which the child reaches the age of 17.²⁵²

Young people in their final years of compulsory education have a range of educational options. These are outlined in section 11B(1) of the *School Education Act 1999*, as follows:

- (1) In the final years of compulsory education a child may, despite section 9(1), participate in one or more of the following options —
 - (a) undertaking —
 - (i) a course of study provided by a university established under a written law or under a law of another State, or of a Territory, of the Commonwealth; or
 - (ii) a higher education course registered under section 23 of the *Higher Education Act 2004* ;
 - or
 - (b) undertaking an approved VET course within the meaning given to that term by the *Vocational Education and Training Act 1996* section 5(1); or
 - (c) being an apprentice; or
 - (d) being employed under a contract of employment otherwise than in a capacity mentioned in paragraph (c), but subject to approval being in force under section 11G; or
 - (e) undertaking a course prescribed under subsection (2).

Young people in Western Australia are typically enrolled at school up to and including year 10. In years 11 and 12, they must be enrolled in an educational program, either by being enrolled at a school or one of the specified options to school, including university courses, vocational education and training courses, apprenticeships, traineeships, community based courses or employment.

²⁵² As at 1 January 2013, these requirements were modified to change the applicable age range for compulsory education from 1 January 2013 until 31 December 2013.

9.2.2 Nineteen of the 20 young people in Group 1 were enrolled at school at the time of their death

All of the 20 young people in Group 1 were at an age at which they were required to either be enrolled in an educational program or employed. Of the 20 young people in Group 1, nineteen (95 per cent) were enrolled in an educational program at the time of their death:

- seventeen were enrolled with a government high school; and
- two were enrolled with a non-government high school.

9.3 Attendance at school

9.3.1 Legislative requirements

Students enrolled at a school are required to attend the classes held at the school. As an alternative, students enrolled at school may also participate in vocational education and training by attending classes at a registered training organisation. Section 24(1) of the *School Education Act 1999* provides:

An arrangement in writing may be entered into for a student —

- (a) to attend at some place other than the school at which he or she is enrolled; and
- (b) there to participate in activities that are part of an educational programme of the school.

In instances where an arrangement has been made for the student to attend classes at a registered training organisation, the principal of the school is responsible for managing the student's attendance. Two young people who were enrolled at government schools had such an arrangement in place.

Section 23(i) of the *School Education Act 1999* provides the **attendance requirements** for students at schools and relevant registered training organisations where an arrangement has been made under section 24(1) of the *School Education Act 1999* (hereafter referred to as the **relevant registered training organisation**):

A student must on the days on which the school is open for instruction -

- (a) either -
 - (i) attend the school at which he or she is enrolled; or
 - (ii) otherwise participate in an educational programme of the school whether at the school or elsewhere,as required by the principal; or
- (b) comply with an arrangement under section 24.

Section 38 of the *School Education Act 1999* places an obligation on parents to ensure that their children meet the attendance requirements set out in section 23. Where section 23 is breached, section 38 of the *School Education Act 1999* provides a penalty. Cases of

persistent non-attendance may be referred to an Attendance Panel for further inquiry, advice and assistance. Section 40(1) of the *School Education Act 1999* provides:

Where a child of compulsory school age enrolled at a school has been persistently in breach of section 23, the child's case may be referred to an Attendance Panel by —

- (a) the principal of the school; or
- (b) an attendance officer; or
- (c) the chief executive officer or the chief executive officer referred to in section 151, as is relevant to the case.

Section 40 (2) of the *School Education Act 1999* provides:

On such a referral a Panel is to —

- (a) inquire into the reasons for the child's failure to comply with section 111 or 23 including the social, cultural, lingual, economic or geographic factors, or learning difficulties, that might be affecting the child's failure to comply; and
- (b) give such advice and assistance to the child and to his or her parents as it thinks fit.

Section 40(5) of the *School Education Act 1999* relevantly provides:

The Panel is to prepare a written report on the child's case setting out any advice or assistance given by the Panel, comments about how the matter had been dealt with and recommendations about how the matter should be dealt with...

Attendance Panels comprise three or more people with the skills, experience and qualifications appropriate to the case. At least one person must be a parent or community representative. A chairperson is nominated by a Regional Executive Director of the Department of Education.²⁵³

In the second reading speech for the *School Education Bill 1997* (which later became the *School Education Act 1999*) The Honourable Colin Barnett, MLA (then Minister for Resources, Development, Energy and Education), stated:

There are many reasons some children fall into a pattern of repeated absence from school. In a number of cases, wilful absence can be traced to an alienation from schooling due to poor achievement, family circumstances or behavioural causes. In some cases, parents or children simply defy the requirement to participate. This area is one in which the need for partnership between school and family is greatest...

²⁵³ Government of Western Australia, Department of Education, *Guidelines for the use of attendance panels*, Department of Education, Perth, 2011, viewed 26 October 2013, <http://det.wa.edu.au/detcms/cms-service/download/asset/?asset_id=14513731>.

Any unauthorised absence is of concern because of the valuable educational time that is lost and because the absence of some children is associated with inappropriate behaviour in the community...

Significant attention has been given to ways of dealing with absenteeism to minimise or avoid prosecuting parents or their children. The establishment and operation of school attendance panels is a major intervention strategy which has been well received. As an independent body its task will be to examine the reasons for a child's absence and to provide appropriate advice to the child, the parents and the school, with the aim of securing the child's regular attendance and participation in the educational program...²⁵⁴

In summary, an Attendance Panel is a small group of people brought together, at the instigation of the principal, attendance officer or Chief Executive Officer of the Department of Education, to inquire into the reasons for a child's non-attendance, provide advice and assistance to the child's parents, and recommend further actions.

The *Parental Support and Responsibility Act 2008* also provides legislative options for engaging with parents to improve a child's school attendance, through the use of responsible parenting agreements and responsible parenting orders. These options are only available to young people 15 years and under, as section 3 of the *Parental Support and Responsibility Act 2008* defines 'child' as a person who is under 15 years of age.

Section 11 of the *Parental Support and Responsibility Act 2008* allows authorised officers of the Department of Education to enter into responsible parenting agreements with parents in respect of a child of the parent. The parents enter into this arrangement voluntarily. Section 11(2) provides that responsible parenting agreements can be made to ensure that the parent is taking all reasonable steps to ensure that the child attends school. There is no penalty for parents not complying with a responsible parenting agreement. However, refusal to comply may lead to the Department of Education applying for a responsible parenting order.

Section 13(1) of the *Parental Support and Responsibility Act 2008* empowers the Chief Executive Officer of the Department of Education, among others, to apply to the Children's Court of Western Australia for a responsible parenting order. Section 18(d) notes that the Court must not make a responsible parenting order unless satisfied that:

A School Attendance Panel has recommended, under section 40 of the *School Education Act 1999*, that an application for a responsible parenting order be made in respect of the child...

As set out in section 14 of the *Parental Support and Responsibility Act 2008*, responsible parenting orders can require a parent to take steps to ensure that their child attends school:

- (1) The Court may, on application, make a responsible parenting order directed towards a parent in respect of a child of the parent.
- (2) A responsible parenting order is an order that requires the parent

²⁵⁴ The Hon. Colin Barnett MLA, Minister for Education, Legislative Assembly, Parliamentary Debates (Hansard), 26 November 1997, pp. 8664 – 8673.

to do one or more of the following —

- (a) attend parenting guidance counselling, a parenting support group, or any other relevant personal development course or group;
- (b) take all reasonable steps to ensure that the child attends school;
- (c) take all reasonable steps to ensure that the child avoids contact with a specified person or specified persons;
- (d) take all reasonable steps to ensure that the child avoids a specified place or specified places;
- (e) comply with any other requirements set out in the order relating to the effective parenting of the child.

Section 21(1) of the *Parental Support and Responsibilities Act 2008* imposes penalties for failing to comply with responsible parenting orders:

If a parent to whom a responsible parenting order or an interim responsible parenting order is directed fails to make reasonable efforts to comply with the order the parent commits an offence.

Penalty: \$200.

Department of Education's policies regarding attendance at school

To operationalise the attendance requirements of the *School Education Act 1999* and the *Parental Support and Responsibility Act 2008* the Department of Education has developed its policy for *Student Attendance (the Student Attendance policy)*, which states:

The Department of Education monitors the attendance of all students enrolled in school, identifies students with attendance issues and implements appropriate measures to restore regular attendance.²⁵⁵

Regular attendance is defined by the Department of Education's *Better Attendance: Brighter Futures Strategy* as attending school 90 per cent of the time.²⁵⁶ Where a student's attendance falls below 90 per cent over a school term, the Student Attendance policy specifies that certain actions are to be taken, as follows:

The principal or nominee will...

- where attendance falls below 90 per cent over a term:
 - further investigate the reasons for the student's absence;

²⁵⁵ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, 2011, Perth, viewed 26 September 2013, <<http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/navigation/student-attendance/?page=2&tab=Main#toc2>>.

²⁵⁶ Government of Western Australia, Department of Education, *Better Attendance, Brighter Futures*, Department of Education, Perth, 2010, viewed 26 September 2013, <<http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/navigation/student-attendance/?page=1&#toc1>>.

- organise a parent/teacher meeting and/or case conference at the earliest opportunity to identify the issues related to the non-attendance and plan for improvement; and
- document all attendance improvement plans.²⁵⁷

In cases of persistent non-attendance the Student Attendance policy also specifies that certain, more formal, actions are to be taken, as follows:

If a student has been identified as being an irregular or chronic non-attende and repeated efforts to work with parents to restore attendance have not been successful, the principal or nominee will:

- consult with an appropriate network or regional officer (or officers);
- inform the parent using Appendix D: *Letter to parent from principal advising of consultation with network or regional officer*; and
- revise any attendance improvement plan developed.²⁵⁸

The Student Attendance policy does not further define 'irregular or chronic' non-attendance. However, the Office of the Auditor General found that attendance less than 60 per cent (that is, the student misses more than two days per week) causes 'severe educational risk.'²⁵⁹

The Student Attendance policy states that, if the student's attendance 'is not successfully restored through consultation with an appropriate network or regional officer, the principal will request the parent attends a formal meeting using *Appendix E: Letter from principal to parent regarding formal meeting*' and:

At the formal meeting, the principal or nominee will:

- ensure any factors preventing attendance or participation are explored;
- request the parent engages with alternative strategies to improve attendance; and
- document a formal attendance improvement plan.

At the formal meeting stage the Student Attendance policy notes that the principal may determine that a responsible parenting agreement may be an appropriate course of action.

If, after the principal has met with the parent, the student's attendance is still not restored, the principal is to refer the matter to the Regional Executive Director:

²⁵⁷ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/attendance.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781800>>.

²⁵⁸ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/attendance.en?bbp.i=d0.a.1.2.1&bbp.8.policyID=13773513&g11n.enc=UTF-8&bbp.9.pane=3&selected=2>>.

²⁵⁹ Office of the Auditor General, *Every Day Counts: Managing Student attendance in Western Australian Public Schools*, Office of the Auditor General, Perth, 2009, p.16.

The principal will refer the matter to the Regional Executive Director where:

- a formal meeting has been unable to secure parental engagement and improvement in school attendance (or engagement in another educational program); and
- it is determined that either prosecution of the parent or application to the Children's Court for a Responsible Parenting Order is appropriate.²⁶⁰

The *Guidelines for the Use of Attendance Panels* identifies that:

An attendance panel is required if an application for a Responsible Parenting Order is being considered and the grounds for recommending an Order relate to persistent non-attendance in isolation from other concerns. This step is mandated by the *Parental Support and Responsibility Act 2008*...and not the *School Education Act 1999*.²⁶¹

For students who are meant to be attending classes at a registered training organisation, arranged pursuant to section 24 of the *School Education Act 1999*, the Student Attendance policy also specifies that the principal is required to manage absences in conjunction with the alternative provider for students.

The principal or nominee will:

- manage absences in conjunction with the alternative provider for students participating in alternative attendance arrangements under Section 24 of the Act...²⁶²

The requirements for managing student attendance, as set out in the Student Attendance policy, are depicted in Figure 42 below.

During the period of the investigation the Department of Education advised that 'it recognises the need to ensure that legislative requirements for attendance are adhered to. The Department's *Strategic Plan for WA Public Schools 2012-2015*, focuses on the importance of ensuring all students attend school regularly as an area requiring attention. *Focus 2014* directs schools to:

- pursue and document attendance of every student not demonstrating regular attendance, bringing to the attention of relevant agencies students at risk, particularly Aboriginal students; and
- use Attendance Advisory Panels and Responsible Parenting Agreements where there is persistent student absence following extensive intervention.

²⁶⁰ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/attendance.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781800>>.

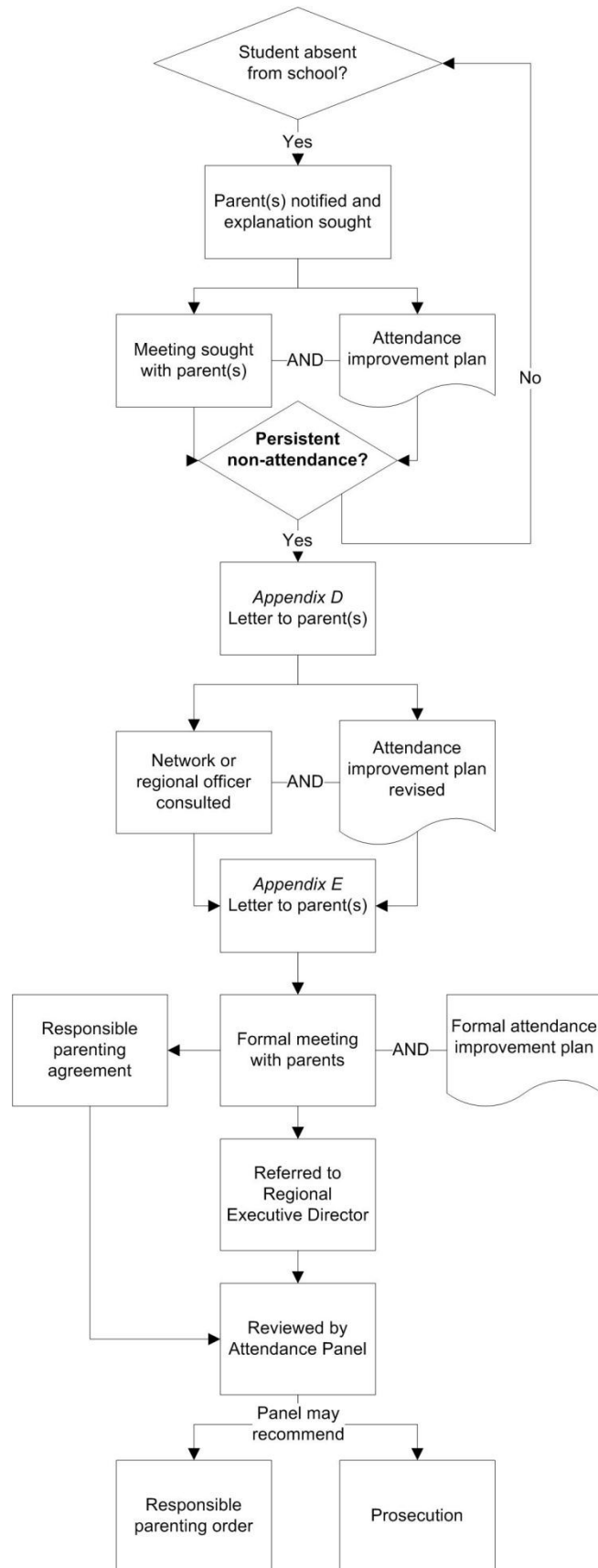
²⁶¹ Government of Western Australia, Department of Education, *Guidelines for the Use of Attendance Panels*, Department of Education, Perth, 2011, viewed 26 October 2013, <http://det.wa.edu.au/detcms/cms-service/download/asset/?asset_id=14513731>.

²⁶² Government of Western Australia, Department of Education, *Department of Education Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/attendance.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781800>>.

Focus 2014 also states that:

- regions and Statewide Services support schools to pursue legislative sanctions where individual attendance plans and case management approaches have not resulted in regular attendance; and
- central office will explore amendments to streamline legislation related to sanctions for persistent student absence.

Figure 42: Department of Education requirements for managing student attendance



Source: Ombudsman Western Australia

9.3.2 During the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60 per cent of the time

Section 9.2.2 above identifies that 19 of the 20 young people in Group 1 were enrolled at school. Therefore, these 19 young people were required to be regularly attending school or the relevant registered training organisation, where such arrangements had been made under section 24 of the *School Education Act 1999*.

Of these 19 young people, 14 (74 per cent) were not regularly attending school or the relevant registered training organisation, as follows:

- seven (37 per cent) effectively did not attend school or the relevant registered training organisation in the last year of their life;
- seven (37 per cent) attended school less than 60 per cent of the time in the last year of their life;
- two (10 per cent) attended between 70 and 89 per cent of the time in the last year of their life;
- two (10 per cent) attended more than 90 per cent of the time in the last year of their life; and
- attendance records could not be obtained for one young person.

9.3.3 Of the 14 young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance

Of the 14 young people who did not meet the attendance requirements set out in the *School Education Act 1999*, the Office found that limited action was taken. In particular, the procedures set out in the Student Attendance policy to address persistent non-attendance were not implemented. The actions taken were as follows:

- for six young people (43 per cent), principals sent letters to the young person's parents or guardian alerting them to the young person's non-attendance. Three letters were sent two or more years prior to the young person's death and three letters were sent within the year prior to the young person's death;
- for five young people (36 per cent) principals asked parents to attend a parent/teacher meeting to identify the issues related to the non-attendance. Two parents attended the parent/teacher meeting and a plan for improvement was discussed and three did not attend the meeting;
- an attendance improvement plan was in place or revised for three young people (21 per cent);
- regional officers were consulted for two young people (14 per cent);
- an Appendix D letter was sent to the parents of two young people (14 per cent); and
- there was no evidence that any of the young people or their parents were referred to the Regional Executive Officer.

In addition:

- there was no evidence that an Appendix E letter was sent to the parents, a responsible parenting agreement was discussed with parents, a formal meeting was arranged with parents and a formal improvement plan was put in place; and
- there was no evidence that there was a referral to the Regional Executive Director, that any of the young people attended an Attendance Panel or that parents were prosecuted, or applications for a Responsible Parenting Order were made.

However a range of other actions, not required by the legislation or policy (*School Education Act 1999*, and the Student Attendance policy) were undertaken by schools. These were as follows:

- participation officers monitored and visited two young people regularly in the year prior to their death. These officers are not provided for in the legislation or policy reviewed, however, the Department of Education's website identifies that 'for young people who are early school leavers and at risk of not participating in education or other approved training or employment programs, special support is available through the Participation Team who broker support for successful transitions and attainment into meaningful pathways';²⁶³
- the Department of Education worked in conjunction with other State government departments to respond to four young people's non-attendance; and
- two young people for whom an arrangement to attend a registered training organisation had been made under Section 24 of the *School Education Act 1999* ceased attending the registered training organisation in the last year prior to their death.

The Office's findings are consistent with the findings of the Office of the Auditor General's 2009 report *Every Day Counts: Managing Student Attendance in Western Australian Public School*. The Auditor-General found:

The Department of Education and Training's [now DOE] current approach to attendance works for the majority of students who are occasionally absent, but the Department of Education and Training has not been successful in addressing persistent non-attendance.²⁶⁴

The Auditor-General also found that a school intervening to restore attendance is not working at most schools, and the school formally referring to the district office is not working because:

²⁶³ Government of Western Australia, Department of Education, *North Metropolitan Education Region, Participation Team*, Department of Education, Perth, viewed 26 September 2013, <www.det.wa.edu.au/regions/northmetropolitan/detcms/navigation/ourservices/participation-team/>.

²⁶⁴ Office of the Auditor General, *Every Day Counts: Managing Student attendance in Western Australian Public Schools*, Office of the Auditor General, Perth, 2009, p. 25.

District office case loads are often so high they cannot contribute what is needed.²⁶⁵

Schools also reported that Attendance Panels were seldom used and not working.²⁶⁶

9.3.4 The names of two young people who died by suicide were on the list of students whose whereabouts were unknown in the year before their death

The Student Attendance policy provides for the possibility that, in extreme cases of irregular or chronic non-attendance, a student may be deemed to be a 'student whose whereabouts is unknown' (prior to 2013, these students were referred to as a 'child whose whereabouts is unknown').²⁶⁷ The Student Attendance policy relevantly provides:

The principal or nominee will refer a student to the Student Tracking Coordinator when he or she is deemed to be a 'child whose whereabouts is unknown'.²⁶⁸

A student is considered to be absent from school when their location is known but they are not attending. However, when a student leaves a school, the school has not received a transfer from another school, and the student cannot be located using school based contacts, then the student is considered 'missing'. Schools may look for students using their own, Department of Education and other agency resources. If a school cannot find a student within three weeks, then the school may apply to the Department of Education to place the student on the list of students whose whereabouts are unknown (**Students whose Whereabouts are Unknown list**). The Student Attendance policy states:

Children Whose Whereabouts are Unknown (CWU) List

A list, usually referred as the CWU List, contains the names of children who are missing from schools and education programs in Western Australia. This list is distributed to administrators in private schools and some agencies by agreement.²⁶⁹

The Department of Education circulates the names of all students on the Students whose Whereabouts are Unknown list to all government and non-government schools in Western

²⁶⁵ Office of the Auditor General, *Every Day Counts: Managing Student attendance in Western Australian Public Schools*, Office of the Auditor General, Perth, 2009, p. 25.

²⁶⁶ Office of the Auditor General, *Every Day Counts: Managing Student attendance in Western Australian Public Schools*, Office of the Auditor General, Perth, 2009.

²⁶⁷ Government of Western Australia, Department of Education, *Students Whose Whereabouts are Unknown (SWU) Guidelines and Procedures*, Department of Education, Perth, 2014, viewed 18 March 2014, <<http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/school-support-programs/behaviour-and-wellbeing/behaviour/sa/related-programs/students-whose-whereabouts-are-unknown-swu-guidelines-and-procedures.en?oid=com.arsdigita.cms.contenttypes.FileStorageItem-id-13453121>>.

²⁶⁸ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/attendance.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781800>>.

²⁶⁹ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/attendance.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781800>>.

Australia, and departments such as Department for Child Protection and Family Support each month during the school year.²⁷⁰

Of the 19 young people in Group 1 who were enrolled at a school:

- the names of two young people were on the Students whose Whereabouts are Unknown list at some point in the year before their death. Both of these young people were referred to the Student Tracking Coordinator. At the time they were on the Students whose Whereabouts were Unknown list, both of these young people had contact with other State government departments and authorities; and
- a further six young people were on the Students whose Whereabouts are Unknown list between Years 1 and Year 10. These young people were taken off the list when they were located. However, in the last year of their life all six young people were attending less than 60 per cent of the time or were effectively not attending school at all.

Recommendation 15: The Department of Education ensures that schools comply with the requirements for addressing student non-attendance, as set out in the *School Education Act 1999* and the *Student Attendance policy*.

Recommendation 16: The Department of Education considers expanding its *Student Attendance policy* to:

- recognise that persistent non-attendance by a student may be due to cumulative harm resulting from child maltreatment;
- recognise that these students may be at heightened risk of suicide;
- set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
- provide that, where this association is identified, it will be appropriately taken into account.

9.4 Behaviour at school

9.4.1 Legislative requirements

With respect to behaviour at school, section 90(1) of the *School Education Act 1999* states that the principal of a government school may suspend from attendance a student who has breached school discipline:

The principal of a government school may wholly or partially suspend from attendance at the school a student who, in the principal's opinion, has committed a breach of school discipline but the principal cannot suspend a student for longer than the period prescribed by the regulations.

²⁷⁰ Office of the Auditor General, *Every Day Counts: Managing Student attendance in Western Australian Public Schools*, Office of the Auditor General, Perth, 2009, p. 33.

A breach of school discipline is defined as ‘any act or omission that impairs the good order and proper management of the school’ (section 89 *School Education Act 1999*). The maximum period of suspension is five days for a breach of school discipline and ten days for a serious breach of school discipline (Regulation 43(1)(a) *School Education Regulations 2000*).

In the second reading speech of the *School Education Bill 1997* (which later became the *School Education Act 1999*), The Honourable Colin Barnett MLA (then Minister for Resources, Development, Energy and Education) stated:

...The Bill makes provision for regulations to be made concerning the discipline of students in government schools. Under the current regulations corporal punishment is prohibited in government schools and this will continue to be the case under the new regulations. Many schools have developed effective strategies for managing student behaviour. It is still necessary, however, to provide support in the Act and regulations to deal with difficult cases. The Bill continues the general provisions of the current Act which authorise suspension and exclusion of those students whose behaviour is inappropriate. Where a breach of school discipline occurs, the school principal will be authorised to suspend a child from attendance at the school up to a maximum time prescribed in the regulations.²⁷¹

With respect to exclusion from school, section 91 of the *School Education Act 1999* provides the power for a student to be excluded from attendance under certain circumstances:

For the purposes of this Division a student may be excluded from attendance at a government school if —

- (a) he or she has committed a breach of school discipline in circumstances that —
 - (i) have adversely affected or threaten the safety of any person who is on the school premises or participating in an educational programme of the school; or
 - (ii) have caused or are likely to result in damage to property; or
- (b) his or her behaviour has disrupted the educational instruction of other students.

Similarly to Attendance Panels, section 93 of the *School Education Act 1999* allows the Minister to appoint a School Discipline Advisory Panel. Section 92 of the *School Education Act 1999* sets out the process for excluding a student from school, including the use of School Discipline Advisory Panels:

Excluding student from school attendance, procedure for

²⁷¹ The Hon. Colin Barnett MLA, Minister for Education, Legislative Assembly, Parliamentary Debates (Hansard). 26 November 1997, pp. 8664 – 8673.

(1) If the principal of a government school is of the opinion that there are grounds under section 91 for the exclusion of a student from attendance at the school, the principal may —

- (a) recommend to the chief executive officer that the chief executive officer exercise his or her powers under section 94; and
- (b) put before the chief executive officer such information as the principal thinks appropriate.

(2) Upon making a recommendation to the chief executive officer, the principal is to notify the student and a parent of the student that the recommendation has been made and provide the parent with the reasons why the recommendation has been made.

(3) The chief executive officer is to refer the recommendation and other information —

- (a) to a School Discipline Advisory Panel under section 93...

...which is to examine the matter and report to the chief executive officer, setting out comments about how the matter had been dealt with and recommendations about how the matter should be dealt with.

...

9.4.2 The Department of Education's policies regarding student behaviour

The Department of Education's policy entitled *Behaviour Management in Schools (the Behaviour Management policy)* outlines the principles and procedures for managing student behaviour, as follows:

Schools provide a social context which allows students to be supported whilst also being taught how to accept responsibility for their own behaviour. Students need opportunities to develop appropriate behaviours, self control, and resiliency through interactions with teachers and other staff and through the curriculum.²⁷²

The Behaviour Management policy identifies that each school should develop a code of conduct that embodies the belief that it is the right of students and staff to be treated fairly and with dignity in an environment free from disruption, intimidation, harassment and discrimination. The code of conduct:

²⁷² Government of Western Australia, Department of Education, *Behaviour management in schools*, Department of Education, Perth, 2008, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/behaviour-management-in-schools.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

Describes the school community's expectations of student behaviour ...including specific behavioural consequences and serious breaches of discipline that adversely affect or threaten safety.²⁷³

The Behaviour Management policy also provides that, in cases where behaviour reaches unacceptable levels, and where it appears to be in the best interest of the school community and/or the student involved, the principal can suspend the student:

The principal can suspend a student from attendance at school when the administrative team consider they have committed a breach of school discipline.²⁷⁴

The Behaviour Management policy identifies that the maximum period of suspension is five days for a breach of school discipline and 10 days for a serious breach of school discipline (a breach of school discipline that adversely affects, or threatens, the safety of a person at the school).²⁷⁵

When a student has been suspended for ten or more days in a school year, consultation with the student's parents must take place, as follows:

When a student has been suspended for a total of 10 or more days in one school year, further consultation with parents must take place to review the behaviour management plan for the student and the educational program being provided.²⁷⁶

If a student accumulates 20 days of suspension in one year the district education office (now known as the educational regional office), must be involved, as follows:

...the school is required to involve the district education office as part of a case management approach. The district education office staff member will assist the school, family and relevant agencies to formally review all aspects of the student's situation and jointly develop a documented plan. This plan must be monitored and reviewed.²⁷⁷

²⁷³ Government of Western Australia, Department of Education, *Behaviour management in schools*, Department of Education, Perth, 2008, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/behaviour-management-in-schools.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

²⁷⁴ Government of Western Australia, Department of Education, *Behaviour management in schools*, Department of Education, Perth, 2008, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/behaviour-management-in-schools.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

²⁷⁵ Government of Western Australia, Department of Education, *Behaviour management in schools*, Department of Education, Perth, 2008, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/behaviour-management-in-schools.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

²⁷⁶ Government of Western Australia, Department of Education, *Behaviour management in schools*, Department of Education, Perth, 2008, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/behaviour-management-in-schools.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

²⁷⁷ Government of Western Australia, Department of Education, *Behaviour management in schools*, Department of Education, Perth, 2008, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/policies/behaviour-management-in-schools.en?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

The Director General's statement, *Managing Student Behaviour*, (**the Director General's statement**) states:

...we want our staff in schools to view student behaviour in educational terms, and have educational strategies to manage it, rather than trying to understand it as a mental health professional might ...

We believe that, even with those students who have been suspended and become alienated from school by their extreme behaviour, there is still scope to re-engage these students. By facing up to what effect their behaviour has had and by making an effort to put things right, students can restore damaged relationships and be reconnected with the school. Those students whose circumstances make it difficult for them to succeed at school often exhibit unproductive behaviours.

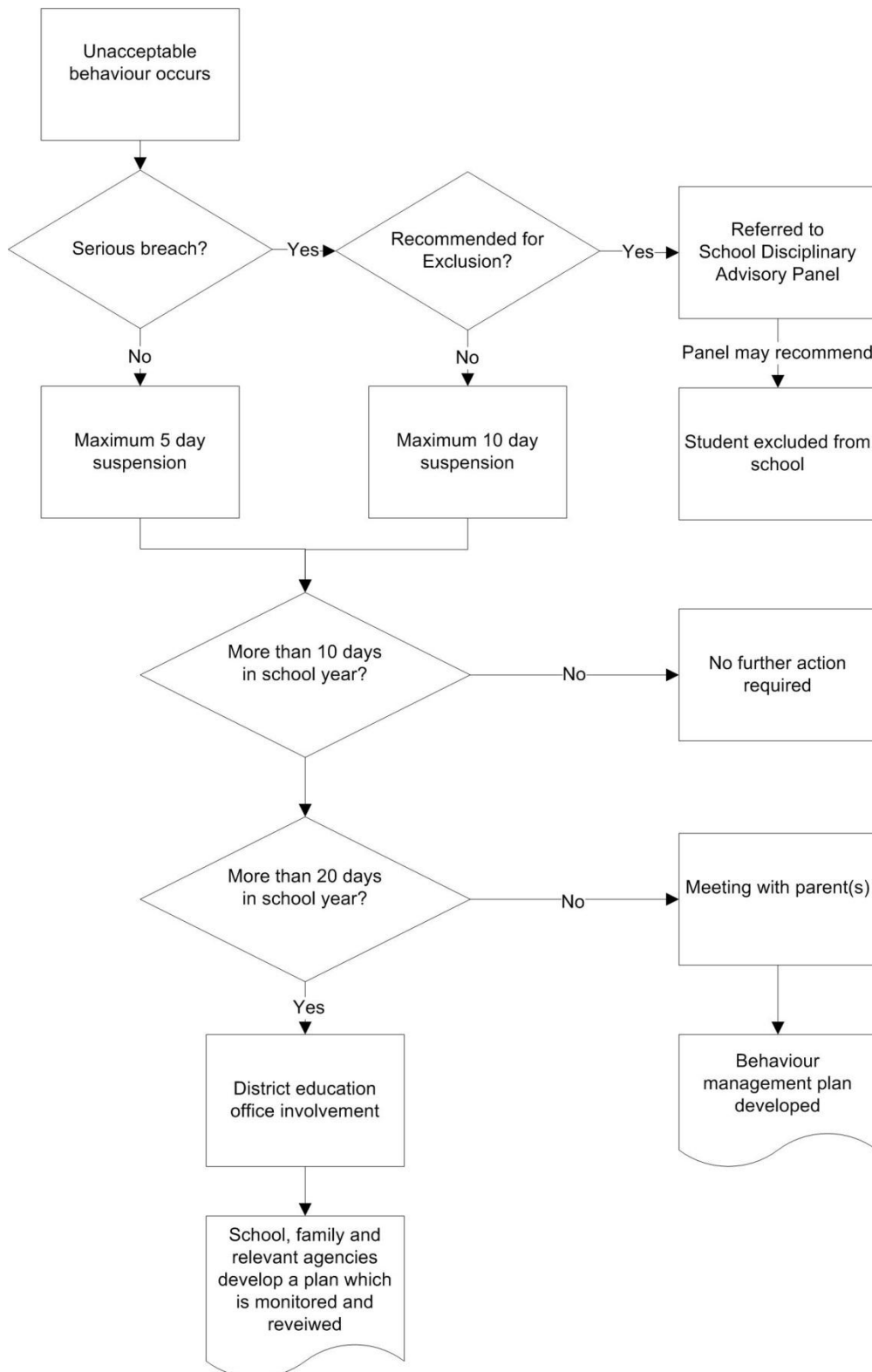
For those students who persistently engage in extremely disruptive behaviour, our school psychologists will help school staff to enable them to put in place individual programs to manage the behaviour and learning of these students. For those who simply cannot be managed in a normal classroom we will provide alternative placements that will give them the intensive help they need with the aim of reintegrating them back into mainstream classes wherever possible.²⁷⁸

In this way, the Director General's statement highlights the role that school psychologists have in assisting teachers with developing behavioural management plans which are required when a student is suspended under the policy and guidelines.

The requirements for managing student behaviour, as set out in the Behaviour Management policy, are depicted in Figure 43 below.

²⁷⁸ Government of Western Australia, Department of Education, *Director General's Statement, Managing Student Behaviour*, Department of Education, Perth, 2009, viewed 26 September 2013, <<http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/director-generals-statements/managing-student-behaviour.en?oid=com.arsdigita.cms.contenttypes.FileStorageItem-id-5064311>>.

Figure 43: Department of Education requirements for managing student behaviour



Source: Ombudsman Western Australia

9.4.3 Ten of the 19 young people enrolled at school had been suspended from school

Of the 19 young people in Group 1 who were enrolled at school at the time of their death, 10 (53 per cent) had been suspended or excluded from school. Nine of the ten young people were suspended on more than one occasion from school.

9.4.4 Five of the 19 young people enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year

The young people who had been suspended from school were suspended for the total number of days in a single school year set out below:

- five young people were suspended from school for less than 10 days in a single school year;
- five young people were suspended for between 10 and 20 days in a single school year; and
- three of these five young people went on to be suspended for over 20 days in a single school year.

9.4.5 A range of actions were taken when young people had been suspended for more than 10 days, however, the relevant policies were not consistently applied

For the five young people who were suspended for ten days or more but less than 20 days over the year, the investigation found that minimal actions were taken. For the three young people who were suspended for 20 days or more over a single year, the investigation found that the following actions were taken:

- two young people were referred to a school psychologist; and
- two young people had a behavioural management plan in place.

For three young people who were repeatedly suspended from school, arrangements were made under section 24 of the *School Education Act 1999* for the young person to attend a registered training organisation.

Recommendation 17: The Department of Education ensures that schools comply with the requirements for managing student behaviour, as set out in its *Behaviour Management in Schools* policy.

Recommendation 18: The Department of Education considers the expansion of its *Behaviour Management in Schools* policy to:

- recognise that ongoing behavioural difficulties by a student resulting in multiple suspensions and exclusions may be due to cumulative harm resulting from child maltreatment;
- recognise that these students may be at heightened risk of suicide;
- set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
- provide that, where this association is identified, it will be appropriately taken into account.

9.5 Aboriginal young people

9.5.1 Department of Education policy regarding enrolment and attendance by Aboriginal young people

The Department of Education requires that every Aboriginal student in Years 1 to 10 has ‘an individual learning plan, as one of the strategies to help close the educational gap between Aboriginal and non-Aboriginal students.’ These requirements are incorporated into the Student Attendance policy:

Regular attendance at school is a critical element in improving students’ literacy and numeracy skills. This in turn impacts on the development of skills and knowledge that improve pathways to work, career choices and financial independence. From Term 1 2010 all Aboriginal students with an attendance rate below 80 per cent are required to have a documented plan to address barriers to attendance, respond to identified educational needs and improve attendance.²⁷⁹

Alternatively, a school can develop a whole school strategy, as follows:

A documented plan does not necessarily need to address all aspects of a student’s educational program, only those aspects that require an individual approach. Schools may develop whole school strategies and write group plans.²⁸⁰

²⁷⁹ Government of Western Australia, Department of Education, *Student Attendance, Appendix A*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policiesframework/policies/attendance.en?bbp.s=9&bbp.e=select&bbp.v=6&bbp.i=d0.1&bbp.8.policyID=13773513&g11n.enc=UTF-8&bbp.9.pane=0>>.

²⁸⁰ Government of Western Australia, Department of Education, *Student Attendance*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policiesframework/policies/attendance.en?bbp.s=9&bbp.e=select&bbp.v=6&bbp.i=d0.1&bbp.8.policyID=13773513&g11n.enc=UTF-8&bbp.9.pane=0>>.

9.5.2 Nine of the ten Aboriginal young people in Group 1 attended school less than 60 per cent of the time

Ten of the 20 young people in Group 1 were Aboriginal. Nine of the 10 Aboriginal young people were enrolled with government schools at the time of their death.

Nine of the 10 Aboriginal young people attended school less than 60 per cent of the time in their last year of life. Attendance records for one young person were not available. The attendance patterns of the nine Aboriginal young people where records were available were as follows:

- three effectively did not attend school in the last year of their life; and
- six attended school less than 60 per cent of the time in the last year of their life.

9.5.3 Of the nine Aboriginal young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance

The nine Aboriginal young people were enrolled at government schools in Term 1 2010. Therefore, for all these nine young people, an individual documented plan, in addition to the actions specified for all students, or a group plan and a whole school strategy, should have been developed.²⁸¹ For these students, the investigation found that the actions set out below were taken:

- letters were sent to parents or guardians of two Aboriginal young people in the last year of their life, and to the parents or guardians of two Aboriginal young people in the three years prior to their death;
- meetings were arranged with parents or guardians of four Aboriginal young people;
- an attendance improvement plan or a whole school strategy were in place for two Aboriginal young people; and
- meetings were held between agencies to facilitate three young people's return to school and/or participation officers monitored and visited regularly.

The findings of the investigation are consistent with those of the State Coroner, who at the completion of his inquests into the deaths of Aboriginal young people in the Kimberley in 2008, and Balgo in 2010, recommended that 'there be a whole of government approach aimed at addressing truancy and its causes, particularly to Aboriginal students in the Kimberley.'²⁸² The Coroner recommended 'students at educational risk as a result of truancy should be monitored and, when necessary, resources of a range of departments should be applied to addressing the issue.'²⁸³

²⁸¹ Government of Western Australia, Department of Education, *Student Attendance, Appendix A*, Department of Education, Perth, 2011, viewed 26 September 2013, <<http://www.det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policiesframework/policies/attendance.en?bbp.s=9&bbp.e=select&bbp.v=6&bbp.i=d0.1&bbp.8.policyID=13773513&g11n.enc=UTF-8&bbp.9.pane=0>>.

²⁸² Coroner's Court of Western Australia, *Inquest into deaths* (F/No: 37/07), Perth, 2008.

²⁸³ Coroner's Court of Western Australia, *'Inquest into deaths'* (F/No: 37/07), Perth, 2008.

During the investigation the Department of Education advised that ‘since 2013 the Department has been working with the Aboriginal Affairs Coordinating Committee on developing actions in relation to a whole of government approach to Aboriginal student attendance.’

9.5.4 Of the ten Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, four were suspended or excluded from school and no action was taken

Of the ten Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, four were suspended or excluded from school. Actions were taken when two young people were suspended from school for more than 10 days during a school year or excluded, as follows:

- meetings were arranged with parents or guardians;
- individual behaviour plans were in place;
- case management planning; and/or
- the involvement of a psychologist.

Recommendation 19: The Department of Education ensures that schools comply with the additional requirements for addressing non-attendance by Aboriginal students, as set out in the *Student Attendance* policy.

9.6 Conclusion

Nineteen of the 20 young people in Group 1 were enrolled at school at the time of their death. However, during the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60 per cent of the time. For the 14 young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance. However, a range of other actions, not required by the legislation or policy (*School Education Act 1999* and the *Student Attendance* policy) were undertaken.

The names of two young people who died by suicide were on the list of students whose whereabouts were unknown in the year before their death. At the time they were on the Students whose Whereabouts were Unknown list, both of these young people had contact with other State government departments and authorities.

With respect to behaviour at school, ten of the 19 young people enrolled at school had been suspended or excluded from school. Five of the 19 young people enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year. A range of actions was taken when young people had been suspended for more than 10 days, and further actions were taken when they were suspended for more than 20 days, however, the relevant policies were not consistently applied.

Nine of the ten Aboriginal young people in Group 1 attended less than 60 per cent of the time. Limited action was taken to remedy this persistent non-attendance.

Recommendation 20: The Department of Education identifies young people who are exhibiting difficulties by establishing internal procedures to track when:

- a young person’s attendance has fallen below 60 per cent;
- a young person’s name has been placed on the Students whose Whereabouts are Unknown List;
- a young person has been suspended from attendance at school on two or more occasions; and
- a young person has been excluded from school.

During the investigation the Department of Education advised that ‘it has established and improved procedures by which student attendance can be tracked to identify students at risk.’

Recommendation 21: The Department of Education uses the information obtained through tracking attendance, suspensions and exclusions to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.

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10 To identify and assist young people at risk of suicide, State government departments and authorities will need to work together as well as separately

Chapters 7 to 9 of this report contain detailed analysis of the contact by the 36 young people with the Department of Health's Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education.

The research literature recognises that coordination between agencies that have contact with young people is essential to achieve appropriate services and supports for those young people at risk of suicide.²⁸⁴ A coordinated approach to suicide prevention for young people can include enhanced communication, joint education, and joint program and system planning, and as an overarching principle, should involve a degree of systemic co-operation.²⁸⁵

The need for coordination between service providers to prevent suicide by young people was also identified by the Commonwealth House of Representatives, in its 2011 report, *'Before it's too late: Report on early intervention programs aimed at preventing youth suicide'*, which stated that:

A significant point of fracture in the system aimed at preventing youth suicide is the lack of collaboration between service providers. There is a large range of services available to young people ranging from early intervention and prevention services to acute psychiatric care for people experiencing significant mental health difficulties or suicidal ideations. However, it seems that communication between these services is patchy at best, and non-existent at worst.²⁸⁶

10.1 The importance of information sharing to effective identification of young people at risk of suicide

The importance of information sharing in preventing the deaths of children and young people was recognised in New South Wales in 2008, through the *Report of the Special Commission of Inquiry into Child Protection Services (the Commission Report)*. The Commission Report found that information sharing is particularly important for identifying the risk of suicide among young people experiencing multiple factors associated with suicide: The Commission also highlighted the importance of information exchange to help:

...identify cumulative harm from a combination of factors and/or over time. Sometimes it only becomes clear that a child or young person has been

²⁸⁴ State of Queensland, Commissioner for Children and Young People and Child Guardian, *Final Report: Reducing Youth Suicide in Queensland*, Commissioner for Children and Young People and Child Guardian, Brisbane, 2011, p. 14.

²⁸⁵ Australian Government, Department of Health, *Models of collaborative care for children and youth (0-25 years)*, Department of Health, 2011, p. 5, viewed 29 October 2013, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-colchild>>.

²⁸⁶ The Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, *Before it's too late: Report on early intervention programs aimed at preventing youth suicide*, Canberra, 2011, p. 36.

harmed, or is at risk, when information from a number of sources is combined to create a complete picture about their circumstances.²⁸⁷

The New South Wales government responded to the Commission Report through a raft of reforms in 2009, collectively known as *Keep Them Safe: A shared approach to child wellbeing*.²⁸⁸ These included legislative amendments regarding information sharing in the *Children and Young Persons (Care and Protection) Act 1998*. The New South Wales government also developed a range of guidance materials to assist relevant government and non-government agencies to implement the changes to the legislation. These included practical tools such as Interagency Guidelines, factsheets, checklists and template letters.

In Western Australia, the primary piece of legislation regarding the safety and wellbeing of children is the *Children and Community Services Act 2004 (the CCS Act)*. Sections 23 and 24A of the CCS Act 'enable agencies to share information, without consent where necessary, in the interests of the wellbeing of a child or class or group of children.'²⁸⁹

Under section 249 of the CCS Act, the Minister for Child Protection is required to carry out a periodic review of the operation and effectiveness of the CCS Act. This review was undertaken by the Department for Child Protection (now Department for Child Protection and Family Support) and a resulting report tabled in Parliament in 2012 (**the Review Report**).²⁹⁰

The Review Report considered the information sharing provisions of the CCS Act, including sections 23 and 24A, and their operation in Western Australia, and found that the information sharing provisions are generally operating effectively to support the objects of the CCS Act.²⁹¹ Sections 23 and 24A of the CCS Act require a comparatively low threshold at which State government departments and authorities are permitted to share information. In relation to these sections, the Review Report found:

Sections 23 and 24A require that any information shared must, in the opinion of the relevant CEO, be, or be likely to be, relevant to "the wellbeing of a child or class or group of children". This is a relatively low threshold: for example, there is no requirement that the information be related to a child's safety or risk of harm or that its disclosure should be for specified purposes. In contrast, the thresholds for sharing information under the NSW and Northern Territory laws, which include sharing between non-government sector agencies, are much higher: there must be a reasonable belief on the part of the disclosing or

²⁸⁷ New South Wales Government, Department of Family and Community Services, *Exchanging information relating to children or young people in a child wellbeing and child protection context*, Department of Family and Community Services, Sydney, 2013, viewed 6 December 2013,

<http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm>.

²⁸⁸ New South Wales Government, *Keep Them: Safe A shared approach to child wellbeing, Keep Them Safe Factsheet No. 3, Legislation Amendments*, Sydney, 2010.

²⁸⁹ Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 11.

²⁹⁰ Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012.

²⁹¹ Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 10.

requesting party that the information will assist in certain ways, e.g. to make a decision, assessment or plan or provide a service.²⁹²

The Review Report supported the maintenance of this lower threshold to enable broader information sharing, recognising that there are existing checks and balances in place.²⁹³

Section 24A of the CCS Act came into effect on 31 January 2011 'to remove barriers to information sharing between government agencies when dealing with matters in which the Department is not involved.'²⁹⁴ Section 24A of the CCS Act:

...enables the CEOs of prescribed authorities to exchange information relevant to the wellbeing of a child or a class or group of children. The public authorities prescribed under this section (in regulation 20A of the *Children and Community Services Regulations 2006*) include WA Police, WA Health, Drug and Alcohol Office, the Departments of Education, Housing, Communities, Corrective Services and the Attorney General, and the Disability Services Commission.²⁹⁵

Nonetheless, some State government departments and authorities indicated that they were aware that information could be shared with the Department for Child Protection and Family Support under the CCS Act and were cooperating with requests for information from the Department for Child Protection and Family Support. However, some State government departments and authorities also reported that they believed the information sharing provisions of the CCS Act only related to exchanges with the Department for Child Protection and Family Support.

Action Area 4 of the State Strategy identifies the need for practical tools for information sharing. In implementing Action Area 4, the Mental Health Commission could consider bringing together the Department of Health's Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education to develop a tool for identifying young people at risk of suicide, using information sourced from a range of State government departments and authorities.

The Department for Child Protection and Family Support has already developed such a risk assessment tool, in collaboration with departments and authorities, in the area of family and domestic violence. These agencies include Western Australia Police, the Department of Corrective Services and the Department of the Attorney General. *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (CRARMF)* recognises that:

Standardised (common) risk assessment and risk management is critical for an integrated response as it ensures that responses are consistent, regardless of where the client enters the system, it creates a shared understanding of risk across all service systems and a common language to communicate risk.

²⁹² Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 14.

²⁹³ Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 14.

²⁹⁴ Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 11.

²⁹⁵ Government of Western Australia, Department for Child Protection and Family Support, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 11.

Common risk assessment and risk management also provide a framework for information sharing and response.²⁹⁶

The CRARMF articulates the relevant legislative and policy framework enabling a common approach, sets out a minimum standard for all State government departments and authorities involved with victims of family and domestic violence, and contains a practice guide for all service providers.

The CRARMF recognises that information sharing is critical as '[s]haring information between services ensures maximum protection for vulnerable women and children.'²⁹⁷ To facilitate such information sharing a '*Memorandum of Understanding: Information sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia* (MOU) was developed to support the State's integrated response to family and domestic violence.'²⁹⁸

10.2 The importance of inter-agency collaboration in preventing and reducing suicide by young people who experience multiple risk factors and have contact with multiple State government departments

As discussed above, Chapter 5 identifies that 19 of the 36 young people (53 per cent) were recorded as having allegedly experienced multiple factors associated with suicide and were recorded as having allegedly experienced one or more forms of child maltreatment, with most also being recorded as experiencing mental health problems and suicidal ideation and behaviour. These 19 young people were all in Group 1. Chapter 5 also identified that the young people in this group had contact with multiple State government departments and authorities over their lifetime.

A 2008 study undertaken by the United Kingdom's former Department for Children, Schools and Families, '*Analysing child deaths and serious injury through abuse and neglect: what can we learn?*' (**the UK Report**) described a profile of young people at risk of serious injury or death, which was similar to those in Group 1. The Report identified that most children who had contact with multiple agencies had the following profile:

- A history of rejection and loss and usually severe maltreatment over many years;
- Parents or carers ... [who] misused substances and had mental health difficulties;
- By adolescence most were typically harming themselves, neglecting themselves, and misusing substances;

²⁹⁶ Government of Western Australia, Department for Child Protection and Family Support, *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, DCPFS, Perth, 2011, p. 3.

²⁹⁷ Government of Western Australia, Department for Child Protection and Family Support, *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, DCPFS, Perth, 2011, p. 39.

²⁹⁸ Government of Western Australia, Department for Child Protection and Family Support, *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, DCPFS, Perth, 2011, p. 41.

- It was difficult to contain these young people in school and in placement.²⁹⁹

In discussing the involvement of these young people with government and non-government agencies, the UK Report identified that:

The theme of older adolescent children who were very difficult to help emerged powerfully. Almost all of these 'hard to help' older young people (over the age of 13) had a long history of high level involvement from children's social care and other specialist agencies, including periods of state care.³⁰⁰

The UK Report further identified that government and non-government agencies:

... appeared to have run out of helping strategies and were sometimes reluctant to assess these young people as mentally ill and/or with suicidal intent. Time was wasted arguing about which agency was responsible for which service and whether thresholds were met, thereby delaying the provision of services that the young people needed. There was a lack of coordination of services for these young people 'in transition' and failures to respond in a sustained way to their extreme distress which occurred in parallel to their very risky behaviour.³⁰¹

Assisting young people, such as those in Group 1, who have been recorded as experiencing multiple risk factors, and preventing or reducing their suicide is likely to involve a range of actions by a range of State government departments and authorities, which will need to be in a coordinated manner so that each action reinforces the others. The report of the *Special Commission of Inquiry into Child Protection Services in NSW (2008)* highlighted:

... the multi-dimensional nature of risks facing vulnerable children and families where factors such as domestic violence, drug and alcohol use or mental health and neglect feature in child protection reporting, none of which can be satisfactorily addressed by any one agency working alone...

The Commission stressed the importance of interagency collaboration in the provision of services to vulnerable children, young people and their families and called for a clear and workable structure for the flow of information to facilitate this collaboration.³⁰²

One accepted way that such coordination can be achieved is through a case management approach. Case management assumes those clients with complex and multiple needs:

²⁹⁹ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

³⁰⁰ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

³⁰¹ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

³⁰² New South Wales Government, Department of Family and Community Services, *Exchanging information relating to children or young people in a child wellbeing and child protection context*, Department of Family and Community Services, Sydney, 2013, viewed 6 December 2013, <http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm>.

... will require a range of services and that this be achieved as seamless service delivery. Case management is based in service provision arrangements that require different responses from within organisations and across organisational boundaries. The process is seen as a boundary spanning strategy to ensure that service provision is client rather than organisationally driven (Case Management Society of Australia 2002). Although there are numerous definitions, the common theme is seen as a process for ensuring that clients are provided with whatever service/s they require in a coordinated, effective and efficient manner.³⁰³

The *National Strategy* recognises the value of a case management approach in implementing the key principle that service delivery will be client-centred. The National Strategy, in Action Area 4, identifies the following strategy:

Develop and promote client centred, shared case-management approaches to suicide prevention in local communities.³⁰⁴

Action Area 4 of the *State Strategy* does not include this reference to a case management approach, although other aspects of Action Area 4 mirror the National Strategy.

One example of a case management approach to young people in Western Australia is the Young People with Exceptionally Complex Needs program (the **YPECN program**). This program was developed in 2012 and was modelled on the pilot of a similar program focussing on adults. A 2010 evaluation of the pilot adult program found that with appropriate support and assistance, people with exceptionally complex needs are able to make and maintain positive changes in their lives, including compliance with medication and reduction in admissions into emergency departments.³⁰⁵

As part of the YPECN program, nine State government departments and authorities work together to provide a coordinated service response to support young people who:

- pose a significant risk of harm to self or others;
- require intensive support;
- would benefit from receiving coordinated services; and
- for whom the existing system is not working as well as it should, and who also have two or more of the following:
 - a mental illness;
 - an acquired brain injury;
 - an intellectual disability; or

³⁰³ New South Wales Government, South Eastern Area Health Service, AIDS Dementia and HIV Psychiatric Service, *Case Management Model*, AIDS Dementia and HIV Psychiatric Service, Darlinghurst, viewed 26 September 2013, <www.health.nsw.gov.au/resources/adaahps/pdf/case_mgt_model.pdf>.

³⁰⁴ Australian Government, Department of Health and Ageing, *National Suicide Prevention Strategy*, Australian Government Publishing Services, Canberra, 2012.

³⁰⁵ Commissioner for Children and Young People, *Submission to the Inspector of Custodial Services Inquiry into the Banksia Hill incident*, Perth, 2013, p. 10.

- a significant substance use problem.³⁰⁶

In 2012, the YPECN program had the capacity to support up to ten young people for a period of up to two years, with a further four referrals under consideration.

A case management approach to assisting individual young people, such as those in Group 1, who have been recorded as experiencing multiple risk factors, could involve:

- a comprehensive assessment to identify the young person's needs;
- a plan for addressing each of the young person's risk factors for suicide;
- as part of this plan, recognising that young people who have experienced multiple risk factors will be hard to engage and therefore require persistent outreach;
- a case manager;
- regular communication between all parties to the case management approach to monitor the effectiveness of their interventions; and
- review and updating of the plan to ensure services remain responsive to changing needs.

The young people in Group 1 had significant levels of contact with the Department of Health's Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. These departments could be important parties to a case management approach. Establishing a case management approach could involve setting in place the necessary management, supervision, reporting and governance arrangements involving these departments. The findings of this investigation, including the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities, could inform the development of such a case management approach.

Recommendation 22: The Mental Health Commission, working together with the Department of Health, the Department for Child Protection and Family Support and the Department of Education, considers the development of a collaborative inter-agency approach, including consideration of a shared screening tool and a joint case management approach for young people with multiple risk factors for suicide.

³⁰⁶ Unpublished information provided by the Mental Health Commission, Western Australia.

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APPENDIX

RECORDED CONTACT WITH STATE GOVERNMENT DEPARTMENTS AND AUTHORITIES, SCHOOLS AND REGISTERED TRAINING ORGANISATIONS BY THE 36 YOUNG PEOPLE WHO DIED BY SUICIDE

1 Introduction

This Appendix draws on information collected in the course of the investigation to provide a more detailed description of the extent and nature of recorded contact by the 36 young people with State government departments and authorities, government and non-government schools, and government and non-government registered training organisations. Organisations are listed in alphabetical order.

So that the Appendix may stand alone as a source of information, it repeats the information which was previously provided in Chapter 5 about recorded contact by the 36 young people with the Department of Health's Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support, government and non-government schools and government and non-government registered training organisations. However, the Appendix should be read in conjunction with Chapter 5 so as to understand the four groupings of young people referred to throughout the Appendix.

To ensure that individual children are not identified by this report, the Office has aggregated the data.

2 Definition of 'contact'

The table below sets out the definition of 'contact' applied during the analysis of the information collected from the organisations who participated in the investigation.

Organisation	Definition of 'contact', as indicated by records
Child and Adolescent Mental Health Service (CAMHS)	Young person was the subject of a referral received by CAMHS, or received services from CAMHS.
Department for Child Protection and Family Support (DCPFS)	Young person was the subject of an interaction with DCPFS; young person directly communicated with DCPFS; young person was the subject of protection action by DCPFS (including being in the care of the CEO). In this report, if a young person had contact with DCPFS, or was part of a family who had contact with DCPFS, we refer to this situation as the young person being known to DCPFS .

Department of Corrective Services (DCS)	Young person was referred to a DCS service by Western Australia Police Officers under section 27 of the <i>Young Offenders Act 1994</i> ; young person was referred by a court under section 28 of the <i>Young Offenders Act 1994</i> ; or young person served time in a custodial facility.
Department of Housing	Young person was part of a family that lodged an application for, or received services from, Department of Housing.
Department of the Attorney General (DOTAG)	Young person received an offer of services from DOTAG regarding its Child Witness Service or Victim Support Services.
Government and non-government schools, and government and non-government registered training organisations	Young person was enrolled with a government or non-government school or government or non-government registered training organisation.
WA Health	Young person received treatment from a hospital Emergency Department; young person received treatment as an inpatient or outpatient of WA Health.
Western Australia Police (WAPOL)	Young person was the subject of a report by WAPOL Officers to DCPFS; young person was charged with an offence by WAPOL.

3 Details of recorded contact between organisations that participated in the investigation and the 36 young people

Child and Adolescent Mental Health Service (CAMHS)

Young people in Group 1 Of the 20 young people in Group 1, eight had been referred by a general practitioner or staff of a hospital emergency department to CAMHS. Three or fewer of these young people were also admitted to hospital for a mental illness.

Young people in Group 2 The four young people in Group 2 who had been diagnosed with a mental illness all presented at CAMHS following referred by a general practitioner.

Young people in Group 3 No contact.

Young people in Group 4 No contact.

Department for Child Protection and Family Support (DCPFS)

Young people in Group 1 Of the 20 young people in Group 1, all had contact with DCPFS, or were part of a family who had contact with DCPFS. We refer to this situation as the young person being '**known to DCPFS.**' Of the 20 young people in Group 1:

- sixteen were known to DCPFS because the Department had received information that raised concerns about the wellbeing of the young person;
- three or fewer young people were known to DCPFS for a variety of reasons, as follows:
 - through a parent's application for financial assistance;
 - because the Department had received information that raised concerns about the wellbeing of the young person's sibling; and/or
 - through a Western Australian Police notification.

Information provided to DCPFS relating to the wellbeing of young people in Group 1 encompassed a number of issues:

- child maltreatment allegations, including allegations of family and domestic violence, neglect, sexual abuse, and physical abuse;
- parental alcohol and substance misuse;
- absconding from places of care;
- access to adequate food or medical care; and
- concerns raised by a member of the public about parenting of a young person.

Reports to DCPFS originated from a number of sources, including members of the community such as family members or neighbours, and from a range of 'professionals,' who had contact with the young people or their families in their professional capacity. This includes:

- Western Australia Police Officers;
- Teachers, psychologists or administrative staff of schools;
- Staff of a hospital or medical centre;
- Staff of the Department of Corrective Services; and

- Staff of a non-government organisation (**NGO**) (for example a youth centre, refuge, or homeless service provider).

Young people in Group 2 No contact.

Young people in Group 3 No contact.

Young people in Group 4 Of the five young people in Group 4, four were known to DCPFS for various reasons as follows:

- through a parent's application for financial assistance;
- DCPFS had received information that raised concerns about the wellbeing of the young person's sibling;
- through a Western Australian Police notification; and/or
- through a parent's request for assistance regarding the young person's sibling.

Department of Corrective Services (DCS)

Young people in Group 1 Of the 20 young people in Group 1, seven were referred to a Juvenile Justice Team under the *Young Offenders Act 1994*, by Western Australia Police officers or by a court.

Three or fewer young people spent time in a custodial facility. All time served by these young people was on the basis of a remand warrant issued by a court. Three or fewer young people were also the subject of a Community Based Order and/or an Intensive Youth Supervision Order.

Young people in Group 2 No contact.

Young people in Group 3 No contact.

Young people in Group 4 Three or fewer young people in Group 4 were referred to a Juvenile Justice Team by a court under section 28 of the *Young Offenders Act 1994*, after having been charged with an offence.

Department of Housing

Young people in Group 1 Of the 20 young people in Group 1, 14 had contact with the Department of Housing as follows:

- at the time of their deaths, seven were listed as registered householders with the Department of Housing;
- four were listed on applications for public housing that

were later withdrawn; and

- three or fewer young people had been registered householders with the Department of Housing in the past but were no longer registered householders at the time of their death.

Young people in Group 2 No contact.

Young people in Group 3 No contact.

Young people in Group 4 Of the five young people in Group 4, three or fewer young people had been registered householders with the Department of Housing in the past but were no longer registered householders at the time of their death.

Department of the Attorney General (DOTAG)

Young people in Group 1 Of the 20 young people in Group 1, four had contact with DOTAG's support services. These young people were all offered services through the Child Witness Services.

Young people in Group 2 No contact.

Young people in Group 3 No contact.

Young people in Group 4 Three or fewer young people in Group 4 were known to DOTAG and offered support services for victims of crime. These offers were not accepted.

Schools and registered training organisations

Young people in Group 1 Of the 20 young people in Group 1:

- seventeen were enrolled in school; and
- three or fewer young people were enrolled full time at a registered training organisation and/or engaged in full time employment.

Of the 17 young people enrolled in school:

- the majority attended a government high school as their last school; and
- three or fewer attended a non-government high school as their last school.

Of the 20 young people in Group 1, seven had contact with a registered training organisation:

- five young people had contact with a government registered training organisation in their school;
- three or fewer young people had contact with a

government registered training organisation on campus; and

- three or fewer young people had contact with a government registered training organisation on campus, and a non-government registered training organisation in their school.

Young people in Group 2 Of the five young people in Group 2, the majority were enrolled in school with fewer young people engaged in full time employment.

Of the young people attending school:

- three or fewer young people attended a government high school as their last school; and
- three or fewer young people attended a non-government school as their last school.

Of the five young people in Group 2, three or fewer young people were or had been enrolled with a registered training organisation and either:

- received training in their school from a government registered training organisation; and/or
- had contact with a government registered training organisation on campus.

Young people in Group 3 Of the six young people in Group 3:

- the majority attended a non-government school as their last school;
- three or fewer young people received training in school from a government registered training organisation or received training in school from a non-government registered training organisation.

Young people in Group 4 Of the five young people in Group 4, three or fewer were in full time employment and were not enrolled at school. Of the five young people in Group 4, all had attended a government high school as their last school.

- four of the five young people in Group 4 had contact with a registered training organisation, and:
- received training in their school from a government registered training organisation;
- had contact with a government registered training organisation on campus; and/or
- had contact with a non-government registered training

organisation on campus.

WA Health

Young people in Group 1 Of the 20 young people in Group 1, 19 young people attended a hospital Emergency Department during their lives. The average number of hospital Emergency Department visits was 10.7 per young person (with a median of 8).

Eleven young people received outpatient care:

- three or fewer young people were treated for Sexually Transmitted Infections,
- eight were treated for fractures;
- seven were treated for mental illness; and
- five were treated for injuries sustained while under the influence of alcohol.

The most common reasons for outpatient care were lacerations or contusions.

Ten young people were admitted to hospital throughout their lives, some more than once for a variety of reasons, including:

- as an involuntary patient under the *Mental Health Act 1996*;
- for bacterial infections;
- for fractures; and/or
- following suicide attempts.

Young people in Group 2 Of the five young people in Group 2, three or fewer attended a hospital Emergency Department, and did so in the last two years of their lives. For these young people the average number of Emergency Department admissions was 2.6 (with a median of 2.3). The young people who attended a hospital Emergency Department had been admitted for various reasons, including:

- for self-harm;
- for depression; and/or
- for mental health related illness.

Young people in Group 3 Three or fewer young people of the five young people in Group 3 attended hospital Emergency Departments.

These young people were treated for chronic illnesses in childhood.

Young people in Group 4 All of the five young people in Group 4 attended a hospital Emergency Department in their lives:

- the average number of Emergency Department admissions was 11; and
- the median number of Emergency Department admissions was 7.

The five young people in Group 4 all were treated as outpatients of hospital Emergency Departments for reasons including:

- treatment of lacerations sufficient to need stitches;
- broken bones;
- sexually transmitted infections; and/or
- viral infections.

Western Australia Police (WAPOL)

Young people in Group 1 Of the 20 young people in Group 1, 15 had contact with WAPOL at some time in their lives. This contact was as follows:

- thirteen of the 15 young people were the subject of reports by WAPOL officers to DCPFS, which are generated when WAPOL have contact with a young person and this contact raises concerns about the safety or wellbeing of the young person; and
- nine of the 15 young people were charged with one or more offences.

For seven of the 13 young people who were the subject of reports by WAPOL Officers, these Officers made multiple reports to DCPFS. Concerns identified in the WAPOL reports to DCPFS included:

- family and domestic violence;
- homelessness;
- sexual or physical harm;
- the absence of a responsible adult;
- absconding;
- violence or aggression; and/or
- apprehension of the young person in Northbridge without a responsible adult under section 41 of the

Children and Community Services Act 2004 .

The most common issue identified in WAPOL reports to DCPFS was family and domestic violence; seven (54 per cent) of the 13 young people were the subject of notifications concerning family and domestic violence.

Three or fewer of the nine young people in Group 1 who had been charged with an offence were charged on multiple occasions. Charges laid involved offences under the *Criminal Code*, *Bail Act 1982*, *Restraining Orders Act 1997*, *Road Traffic Act 1974* or *Road Traffic (Vehicle Standards) Regulations 1992*.

All charges against the young people in Group 1 were referred for hearing by the Children's Court of Western Australia.

Young people in Group 2 No contact.

Young people in Group 3 No contact.

Young people in Group 4 Of the five young people in Group 4, three or fewer had contact with WAPOL, as follows:

- as the subject of a WAPOL notification to DCPFS; and/or
- were charged with an offence under the *Criminal Code Act Compilation Act 1913*.

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