Preventing suicide by children and young people 2020

Volume 3: Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people

Ombudsman Western Australia
Serving Parliament – Serving Western Australians

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The office of the Ombudsman acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of Australia. We recognise and respect the exceptionally long history and ongoing cultural connection Aboriginal and Torres Strait Islander people have to Australia, recognise the strength, resilience and capacity of Aboriginal and Torres Strait Islander people and pay respect to Elders past, present and future.

CONTENT WARNING

This report contains information about suicide by children and young people and child abuse that may be distressing. We wish to advise Aboriginal and Torres Strait Islander readers that this report also includes information about Aboriginal and Torres Strait Islander children and young people who died by suicide.

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1. Suicide by children and young people

1.1 Definitions

> ## A note on the defined terms in this report
>
> *People affected by suicide are vulnerable and can fear the reaction of others. We need to talk more about suicide and make sure we talk about it in a way that is helpful and healthy.*[1]
>
> *Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need. …*
>
> *Raising community awareness and breaking down the taboo is important for countries to make progress in preventing suicide.*[2]

In this section, we define key terms used throughout the report. In doing so, the office of the Ombudsman (**the Office**) has carefully considered that inappropriate language used to describe suicide, suicidal thoughts, suicidal behaviours and attempts, self-harm and mental ill-health can be insensitive, stigmatising and 'alienate members of the community or inadvertently contribute to suicide being presented as glamorous or an option for dealing with problems'.[3]

1.1.1 The 115 children and young people

The Ombudsman's major own motion *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (**the 2014 Investigation**) analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner had 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 had not yet completed an investigation). In this report, as in the 2014 Investigation, we refer to these young people as **the 36 young people**.[4]

During the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people* (**the 2020 Investigation**), the Office analysed an additional 79 deaths in which a child or young person had either died by suicide (as determined by the State Coroner) or was suspected of having died by suicide (for those deaths the State Coroner had not yet completed an investigation). In this report, these children and young people are referred to as **the 79 children and young people**.[5] We also refer to the 36 young people and the 79 children and young people, collectively as **the 115 children and young people** (Figure 1).

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[1] Beyond Blue, *Language when talking about suicide*, viewed 21 September 2018, <https://www.beyondblue.org.au/the-facts/suicide-prevention/worried-about-suicide/having-a-conversation-with-someone-you're-worried-about/language-when-talking-about-suicide>.

[2] World Health Organization, *Fact Sheet: Suicide*, viewed 22 September 2018, <http://www.who.int/news-room/fact-sheets/detail/suicide>.

[3] Everymind, *Language and suicide*, viewed 26 February 2019, <http://www.mindframe-media.info/__data/assets/pdf_file/0011/9983/Mindframe-for-media-book.pdf>.

[4] The 36 young people considered as part of the 2014 investigation died by suicide over a 3.5-year period.

[5] The 79 children and young people considered as part of the 2020 investigation died by suicide over a 5.5-year period.

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Figure 1: The 115 children and young people who died by suicide in Western Australia, by Ombudsman Investigation and Group

GROUP 1
Children and young people who experienced multiple factors associated with suicide

GROUP 2
Young people diagnosed with mental illness and/or demonstrated significant planning of their suicide

GROUP 3
Children and young people who experienced few factors associated with suicide

GROUP 4
Young people who experienced few factors associated with suicide and demonstrated impulsive or risk taking behaviour

36
Young people who died by suicide and were included in the 2014 investigation

79
Children and young people who died by suicide and were included in the 2020 investigation

Key:

Aboriginal Child aged 10-13

Non-Aboriginal Child aged 10-13

Aboriginal Young Person aged 14-17

Non-Aboriginal Young Person aged 14-17

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1.1.2 Young person

In this report, we use the terms 'young person' or 'young people' to refer to 14 to 17-year-olds. Young people of 14 to 17 years are commonly referred to as 'adolescents' or 'teenagers' in the research literature, as well as sometimes being included within a broader category of 'youth' that may extend to include people aged up to and including 24 years[6] (when the brain ordinarily reaches maturity)[7]. The research literature observes that:

> The significance of high numbers of suicide attempts within the adolescent period no doubt has links with the developmental process. Adolescence is the most turbulent developmental period since infancy with the biggest challenges and changes in all three areas of biological, psychological and social change. Predisposing vulnerabilities can be activated during the adolescent phase. Outside the adolescent period the only other time in life where such rapid changes, initiated by the hypothalamus, occur is in the womb.[8]

During this period, young people experience several significant developmental changes, including:

- significant physical growth and changes in their bodies associated with puberty;[9]

- developing self-concepts of identity, morality and ethics, sexuality, gender and culture;[10] and

- facing new social challenges such as increased academic and peer pressures, relationships and employment.[11]

The research literature also observes that:

> … there is a significant developmental lag between the intensification of emotional and behavioural states that accompany the hormonal changes of puberty in early adolescence and the mastery of cognitive and emotional coping skills that are enabled through cortical development during late adolescence and early adulthood. This lag leaves vulnerable adolescents prone to increased moodiness with biased interpretations of experiences, self-criticality, poor judgment … emotion-focused coping [and] may also contribute to the increase in suicidal ideation that has been observed as youth move through the middle school years. Young adolescents are particularly vulnerable to perceiving problems as overwhelming and to seeking "all or nothing" solutions.[12]

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[6] Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

[7] Arain M et al, 'Maturation of the adolescent brain', *Neuropsychiatric disease and treatment*, vol. 9, 2013, pp. 449-461 doi: 10.2147/NDT.S39776.

[8] Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 18.

[9] Stanford Children's Health, *The Growing Child: Adolescent (13 to 18 Years)*, viewed 18 February 2019 <https://www.stanfordchildrens.org/en/topic/default?id=the-growing-child-adolescent-13-to-18-years-90-P02175>.

[10] American Psychological Association, *Developing Adolescents: A Reference for Professionals*, viewed 18 February 2019, <https://www.apa.org/pi/families/resources/develop.pdf>.

[11] Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

[12] Vander Stoep A et al 'Thoughts of Death and Suicide in Early Adolescence', *Suicide and Life-Threatening Behavior*, vol 39 no.6, 2009, pp. 599-613, doi: 10.1521/suli.2009.39.6.599.

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1.1.3 Children

In this report, we primarily use the term 'child' to refer to 10 to 13 year-olds who died by suicide or engaged in self-harming behaviour, although on some occasions this age range is broader or narrower, due to differences in data collection and reporting by relevant agencies. Where this is the case, we clearly note this in the relevant text or figure.

Children 10 to 13 years are commonly referred to as 'pre-teens', 'tweens', 'early-adolescents', and 'pre-adolescents' in the research literature. Between 10 and 13, children are growing physically, cognitively, socially and emotionally, becoming more aware of themselves as individuals and working hard to gain proficiency at a range of more complex tasks. Girls may also reach puberty.[13]

The research literature observes significant differences in executive functioning between children, young people and adults, as follows:

> Recent research demonstrates that there is a surge in the production of gray matter just before puberty (peaking at age 11 for girls, 12 for boys), largely affecting the frontal cortex, where executive functions are housed. (Executive functions include the ability to think, plan, maintain short-term memory, organize thoughts, control impulses, problem solve, and execute tasks.) This same research finds myelination of the gray matter develops slowly, with this region not fully maturing until young adulthood.
>
> Prior to the maturation of the frontal lobes, young teens seem to use the amygdala to process emotions, a brain center responsible for mediating fear and other gut reactions. In addition, when shown emotionally loaded images or situations, [these younger] teenage brains showed responses that were greater in intensity than were either younger children or adults. Research demonstrates adults use the frontal lobe as opposed to the amygdala for such processing. Scientists thus posit that the parts of the brain responsible for emotional responses are fully developed, possibly even hyper-reactive in young adolescents, compared to adults. However, the parts of the brain responsible for keeping emotional, impulsive responses in check have not reached maturity, and thus children this age aren't yet capable of making decisions that accurately assess risk or that are free of impulsivity.[14]

1.1.4 Records

In this report, 'records' is defined as the records of State Government departments and authorities obtained during the 2020 investigation.

1.1.5 Aboriginal and/or Torres Strait Islander children and young people

The Offices recognises and deeply respects the Aboriginal communities who are the original inhabitants of Western Australia.

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[13]Department of Communities, *Child development and trauma guide*, viewed
27 October 2019, <https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Documents/ChildDevelopment AndTraumaGuide.pdf>.
[14]Anthony M, *Social Development in 11-13 Year Olds*, Scholastic, viewed 22 September 2018,
<https://www.scholastic.com/parents/family-life/social-emotional-learning/development-milestones/social-development-11-13-year-olds.html>.

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In this report, the Office uses the terms 'Aboriginal' and 'Torres Strait Islander' to describe the identity of children and young people who have died by suicide. When we refer to a group of children and young people including both Aboriginal children and young people and Torres Strait Islander young people, we use the phrase 'Aboriginal and Torres Strait Islander children and young people'. We also use the term 'Aboriginal and/or Torres Strait Islander' when referring to the population.

1.1.6   Gender and sex

> ## A note on the consideration of gender identification and biological sex in this report
>
> This section of the report sets out the defined terms used in this report relating to gender and sex. Additional consideration is given to this issue and related matters in the following Chapters of this volume:
>
> - Chapter 3.5.3, which considers the biological sex of the 115 children and young people;
>
> - Chapter 3.5.4, which considers the patterns and trends relating to biological sex across different age groups of the 115 children and young people;
>
> - Chapter 3.5.10, which considers gender identity and sexual orientation recorded for the 115 children and young people;
>
> - Chapters and 4.4.2.2 and 4.5.4.2, which consider the biological sex of the children and young people who were hospitalised or presented to emergency departments, respectively, for self-harm, suicidal ideation and suicidal behaviours; and
>
> - Chapter 6.4.2.2, which considers the biological sex of the Aboriginal and Torres Strait Islander children and young people who died by suicide.

As noted by the Australian Bureau of Statistics, sex and gender are 'interrelated concepts'.[15] However the 'difference between sex and gender is not well understood … with the two concepts often used interchangeably in legislation, research, and the media.[16]

The World Health Organization defines 'sex' as the 'different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, [and] hormones'.[17]

Similarly, the Australian Government Guidelines on the Recognition of Sex and Gender identify that:

> … sex refers to the chromosomal, gonadal and anatomical characteristics associated with biological sex.

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[15] Australian Bureau of Statistics, 'Introduction', *Standard for Sex and Gender Variables*, cat. no. 1200.0.55.012, ABS, Canberra, February 2016.

[16] Australian Bureau of Statistics, 'Introduction', *Standard for Sex and Gender Variables*, cat. no. 1200.0.55.012, ABS, Canberra, February 2016.

[17] World Health Organization, *Gender, Equity and Human rights: Glossary of terms and tools*, viewed 26 February 2019, <https://www.who.int/gender-equity-rights/knowledge/glossary/en/>.

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> The term intersex refers to people who are born with genetic, hormonal or physical sex characteristics that are not typically 'male' or 'female'. Intersex people have a diversity of bodies and gender identities, and may identify as male or female or neither. …

> Although sex and gender are conceptually distinct, these terms are commonly used interchangeably, including in legislation.

> A person's sex and gender may not necessarily be the same. Some people may identify as a different gender to their birth sex and some people may identify as neither exclusively male nor female.[18]

The World Health Organization defines 'gender' and its relevance to a person's health and wellbeing as follows:

> **Gender** refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories.

> Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. They also have a bearing on people's access to and uptake of health services and on the health outcomes they experience throughout the life-course.[19]

In the 2016 Census, the Australian Bureau of Statistics made it possible to report and collect data on sex and gender diversity for the first time. It has an operational definition of 'gender' as referring to:

> … the way in which a person identifies their masculine or feminine characteristics. A person's gender relates to their deeply held internal and individual sense of gender and is not always exclusively male or female. It may or may not correspond to their sex at birth. As gender is determined by the individual, it can therefore be fluid over time.

> The reported descriptions of sex/gender diversity are defined as follows:

> - **Intersex/Indeterminate** - Intersex people are those who are born with genetic, hormonal or physical characteristics that are not typically 'male' or 'female'. Intersex people have a diversity of bodies and identities. A person of indeterminate sex or gender is either someone whose biological

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[18] Australian Government, *Australian Government Guidelines on the Recognition of Sex and Gender*, November 2015,
viewed 26 February 2019, <https://www.ag.gov.au/Publications/Documents/AustralianGovernmentGuidelinesontheR ecognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.pdf>, p. 4.
[19] World Health Organization, *Gender, Equity and Human Rights: Gender*, viewed 26 February 2019,
<https://www.who.int/gender-equity-rights/understanding/gender-definition/en/>.

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sex cannot be unambiguously determined or someone who identifies as neither male nor female.

- **Trans male** - A transgender person who was born female but whose gender identity is male. Also may include people assigned female at birth who are transitioning from female to male sex.

- **Trans female** - A transgender person who was born male but whose gender identity is female. Also may include people assigned male at birth who are transitioning from male to female.

- **Transgender not elsewhere classified (nec)** - A person whose gender identity is different from their sex at birth and has not indicated that they are trans male or trans female.

- **Non-binary** - A person who identifies as non-binary.

- **Another gender** - A person who has multiple genders, is gender neutral, is gender fluid or has another identity not covered by the rest of the categories. This a separate category to Non-binary in this descriptor set because this set groups similar terms together, using the term provided by respondents.

- **Other not further defined (nfd)** - A person who does not identify as male or female, without any further qualifying information about their gender or sex identity.[20]

More recently, in its review of Western Australian legislation in relation to the recognition of a person's sex, change of sex or intersex status, the Law Reform Commission of Western Australia acknowledged that:

> … challenges affecting the intersex, trans and gender diverse communities are highly personal. It also acknowledges that as language evolves over time, terminology may mean different things to different people.[21]

The Law Reform Commission of Western Australia also adopted the following definitions of 'gender', 'gender identity' and 'trans and gender diverse':

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[20]Australian Bureau of Statistics, 'Sex and Gender Diversity in the 2016 Census', *Census of Population and Housing: Reflecting Australia – Stories from the Census*, cat. no. 2071.0, ABS, Canberra, November 2016.
[21]Law Reform Commission of Western Australia, Final Report: Review of Western Australian legislation in relation to the registration or change of a person's sex and/or gender and status relating to sex characteristics, Perth, November 2018, p. 12.

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Term	Description
Gender	Gender refers to how a person identifies, the ways they express their personal and social identity and the way they are recognized within a community.
Gender identity	A person's deeply felt sense of being a man, a woman, both, in between, neither or something other. It is recognized that a person's sex as registered at their birth may not necessarily be the same as that person's gender identity.
Trans or Trans and gender diverse	Trans and gender diverse is an umbrella term used to describe all people whose gender identity is different to the sex they were assigned at birth. Under the broad trans and gender diverse umbrella are more specific terms that some trans and gender diverse people may use.

Source: Law Reform Commission of Western Australia[22]

The personal challenges and experiences of people born with intersex variations, transgender and gender-diverse people whose genetically assigned sex differs from their gender identity, illustrate the 'important distinction between sex and gender.'[23] For this reason, the Office has sought to use inclusive terminology throughout this report when discussing sexual orientation and gender identity.

The Office also acknowledges that, given that the 2020 investigation analysed 115 deaths in which a child or young person died by suicide:

- our data with respect to gender identity and sexual orientation of these children and young people (as drawn from the records of State Government departments and authorities) is unlikely to be complete; and

- comparable population data relating to self-harm and suicide published by agencies such as the Australian Bureau of Statistics is currently only reported with reference to biological sex.

Accordingly, as a result of these methodological limitations we use the word 'sex' to refer to the set of biological features that define the different types of sexes, that is, males, females and others (those with mixed or non-binary biological characteristics, or who were assigned a non-binary sex at birth).

In this report, we also use the words 'male' and 'female' as meaning:

- **Male**: persons recorded as displaying primarily male or masculine biological characteristics, or as male sex assigned, in State Government records; and

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[22]Law Reform Commission of Western Australia, Final Report: Review of Western Australian legislation in relation to the registration or change of a person's sex and/or gender and status relating to sex characteristics, Perth, November 2018, pp. 12-13.
[23]Law Reform Commission of Western Australia, Final Report: Review of Western Australian legislation in relation to the registration or change of a person's sex and/or gender and status relating to sex characteristics, Perth, November 2018, p. 12.

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- **Female**: persons recorded as displaying primarily female or feminine biological characteristics, or as female sex assigned, in State Government records.

However, our discussion of this data is in no way intended to obscure or minimise the needs and experiences of children and young people whose gender identity differs from their sex. For this reason, as noted at the beginning of this section, further consideration of the recording of sex and gender identity data by State Government departments and authorities is included in Chapters 3 and 4 of this volume.

1.1.7 Suicide

Suicide is defined by the World Health Organization as 'an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome.'[24] In this report, we use the word suicide to refer to deaths in which the State Coroner has:

- completed an investigation and found that the cause of a child or young person's death was suicide or made an open finding indicating that suicide may have been the cause of a child or young person's death; or

- not completed an investigation, but the circumstances in which a child or young person died (as detailed in the initial Coronial Notification of death to the Office) indicate that they died by suicide.[25]

This report also uses the word 'suicide' to refer to data reported by the Australian Bureau of Statistics (**ABS**) about the 'number of deaths attributed to intentional self-harm'[26] in Australia, including deaths:

- determined by a coroner to be a suicide;[27] and

- coded by the ABS as a suicide if evidence held on the National Coronial Information System indicates that the death was from intentional self-harm.[28]

The ABS codes deaths in accordance with the International Classification of Diseases (**ICD-10**), which 'is the international standard classification for epidemiological purposes … used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records'.[29] The relevant ICD-10 codes relating to intentional self-harm are X60-X84, and Y87.0.

1.1.8 Suicidal behaviour

The World Health Organization defines suicidal behaviour as:

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[24]World Health Organization, The World Health Report 2001 – Mental Health: New Understanding, New Hope, WHO, Geneva, Switzerland, 2001, p. 37.
[25]Mendoza J and Rosenberg S, *Suicide and Suicide Prevention in Australia: Breaking the Silence,* Lifeline Australia and Suicide Prevention Australia, 2010, p. 12.
[26]Australian Bureau of Statistics, 'Explanatory Notes' *Causes of Death, Australia, 2016*, cat. no. 3303.0, ABS, Canberra, September 2017.
[27]Australian Bureau of Statistics, 'Explanatory Notes' *Causes of Death, Australia, 2016*, cat. no. 3303.0, ABS, Canberra, September 2017.
[28]Australian Bureau of Statistics, 'Explanatory Notes' *Causes of Death, Australia, 2016*, cat. no. 3303.0, ABS, Canberra, September 2017.
[29]Australian Bureau of Statistics, 'Explanatory Notes' *Causes of Death, Australia, 2016*, cat. no. 3303.0, ABS, Canberra, September 2017.

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> [A] range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself. The inclusion of ideation in suicidal behaviour is a complex issue about which there is meaningful ongoing academic dialogue. The decision to include ideation in suicidal behaviour was made for the purpose of simplicity since the diversity of research sources … are not consistent in their positions on ideation.[30]

Throughout this report, as in the 2014 Investigation Report, we use 'suicidal behaviour' to refer to non-fatal suicidal thoughts (**suicidal ideation**), conversations or other communication in which a child or young person expresses the wish or intent to die (**communicated suicidal intent**), and recorded previous suicide attempts. These thoughts and actions are also sometimes referred to as 'suicidality' in other publications.[31]

1.1.8.1   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.[32]

The research literature further identifies that:

> The term 'suicidal ideation' refers to thoughts that life is not worth living … These thoughts are not uncommon among young people. **It is estimated that between 22% and 38% of adolescents have thought about suicide at some point in their lives, with between 12% and 26% reporting having had such thoughts in the previous year** [original emphasis].

> The majority of young people who experience suicidal ideation will not go on to take their lives, however any report of suicidal ideation should be taken seriously. Even when it is mild, and is only reported on one occasion, suicidal ideation has been found to be associated with clinically significant symptoms of depression. Furthermore, **young people experiencing persistent, severe suicidal ideation are at increased risk of attempting suicide** [original emphasis].[33]

In this report, as in the 2014 Investigation, we use 'suicidal ideation' to refer to records indicating that a child or young person had thoughts about attempting or completing suicide.

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[30]World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 12.
[31]For example, see Slade T et al, The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing, Department of Health and Ageing, Canberra, 2009.
[32]American Psychiatric Association, *Diagnostic and statistical manual of mental disorders, 4th ed*, Masson, Barcelona, 2003.
[33]Scanlan F and Purcell R, Mythbuster, Suicidal ideation, MYTH: Asking young people about suicidal thoughts or behaviours will only put ideas into their heads, headspace, National Youth Mental Health Foundation Australia, 2009, viewed 26 October 2019, <https://headspace.org.au/assets/Uploads/Resource-library/Health-professionals/suicidal-ideation-mythbusterv2.pdf>, p. 1.

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1.1.8.2   Suicidal intent

Suicidal intent is defined as:

> Active suicidal thoughts of killing oneself and [the child or young person] reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them."[34] [original emphasis]

Suicidal intent may also occur with a specific plan to die by suicide.[35] In this report, as in the 2014 Investigation, we use 'suicidal intent' to refer to instances where records indicate that a child or young person has actively communicated to another person:

- a desire to end their life; or

- concrete, well-thought out plans to take their own life using lethal means.

1.1.8.3   Suicide attempt

The United States Centres for Disease Control and Prevention defines 'suicide attempt' as meaning:

> A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.[36]

In contrast, other research literature, including the 2014 World Health Organization report *Preventing Suicide: A global imperative*, uses 'suicide attempt' to refer to 'any non-fatal suicidal behaviour and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome'.[37] This definitional difference arises from the difficulties in reliably distinguishing between attempted suicide and self-harm in certain circumstances, as follows:

> It is important to acknowledge the implications and complexities of including self-harm in the definition of "suicide attempt". This means that non-fatal self-harm without suicidal intent is included under this term, which is problematic due to the possible variations in related interventions. However, suicide intent can be difficult to assess as it may be surrounded by ambivalence or even concealment.
>
> In addition, cases of deaths as a result of self-harm without suicidal intent, or suicide attempts with initial suicidal intent where a person no longer wishes to die but has become terminal, may be included in data on suicide deaths. Distinguishing between the two is difficult, so it is not possible to ascertain

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[34]Posner K, et al, *Columbia-Suicide Severity Rating Scale (C-SSRS): Pediatric – Since Last Contact – Communities and Health Care*, viewed 26 March 2019, <https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf>.

[35]Posner K, et al, *Columbia-Suicide Severity Rating Scale (C-SSRS): Pediatric – Since Last Contact – Communities and Health Care*, viewed 26 March 2019, <https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf>.

[36]Centres for Disease Control and Prevention, *Definitions: Self-directed Violence*, viewed 22 September 2018, <https://www.cdc.gov/violenceprevention/suicide/definitions.html>.

[37]World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 12.

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what proportions of cases are attributable to self-harm with or without suicidal intent.[38]

In this report, consistent with the 2014 Investigation, we use 'suicide attempt' when referring to instances where records state that a child or young person has attempted to end their own life.

1.1.9 Self-harm

The National Centre of Excellence in Youth Mental Health (**Orygen**), provides the following definition of self-harm:

> Self-harm is when someone deliberately hurts or mutilates their body without meaning to die, although death may still occur as a result of the self-harming behaviour. Self-harming is a behaviour and not in itself a diagnosable mental disorder. Self-harm often occurs in young people who experience depression, anxiety, behavioural problems (such as conduct disorder) and substance use.[39]

Self-cutting and overdose are the most common methods of self-harm in children and young people.[40]

Self-harm can also include other behaviours such as:

- jumping from a height;

- cutting, burning or picking skin;

- plucking or pulling hair;

- punching or hitting one's self;

- deliberate starvation or ingestion of non-ingestible substances or objects; and

- substance use above the prescribed or therapeutic dose.[41]

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[38]World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 12.
[39]Orygen, The National Centre of Excellence in Youth Mental Health, *Fact Sheet: Self harm + young people*, 2017, viewed 22 September 2018, <https://oyh.org.au/sites/oyh.org.au/files/factsheets/OYH_Self_harm_youngpeople.pdf>, p. 1.
[40]De Leo D and Heller T, '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.
[41]Connetica, *Suicide in Australia – Key Facts*, May 2016, viewed 13 September 2018, <https://static1.squarespace.com/static/5858b2276b8f5be324ffefff/t/5898ff2f15d5dba05f6c9c9d/1486421825261/media_backgrounder_-_suicide-suicide_prevention_australia_may_24_final.pdf>, pp. 5-6.

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In the research literature, several terms are used to describe self-harm, including deliberate[42] or intentional self-harm[43], non-suicidal self-injury[44], self-injurious behaviour[45] and parasuicide.[46]

In this report, as in the 2014 Investigation, we use the term 'self-harm' to refer to instances where records indicate that a child or young person has deliberately harmed himself or herself. International, national and state-wide self-harm data presented in this report is based on the ICD codes for intentional self-harm that does not cause death (unless otherwise stated).[47]

1.1.10 Risk

Risk is defined in the National Standards for Mental Health Services as:

> The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood.[48]

The World Health Organization identifies that risks relating to suicidal and self-harming behaviours can arise as a result of 'systemic, societal, community, relationship and individual … factors that are reflective of an ecological model'.[49]

In the Western Australian context, the Department of Health highlights that mental health providers are primarily concerned 'about risks that are highly likely in terms of probability and that have severe consequences, such as imminent suicide attempts or violence'.[50]

The Department of Health also notes in its *Principles and Best Practice for the Care of People Who May Be Suicidal* document that, historically, assessments of a person's risk of suicide or self-harm were conducted through the use of standardised risk scales, tools and checklists aimed at 'the *prediction* of risk … [through] stratifying patients into categories of high, medium or low risk,'[51] however:

> The challenges for an individual clinician faced with the assessment of a person who may be suicidal are twofold: firstly, it is an uncommon event, even within mental health services, with rates of around one person per one

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[42]Carter G et al, *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guideline for the Management of Deliberate Self-Harm*, 2016, viewed 18 February 2019, <https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/deliberate-self-harm-cpg.aspx>.

[43]Australian Bureau of Statistics, 'Explanatory Notes', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

[44]Child and Adolescent Health Service, ''Guideline: Self-injury (Non-suicidal self-injury)', *Community Health Manual*, Government of Western Australia, Perth, November 2017.

[45]Gordon M and Melvin G, 'Risk assessment and initial management of suicidal adolescents', *Australian Family Physician*, vol. 46 no. 6, June 2014, pp. 367-372.

[46]McNeill Y, Gillies M and Wood S, 'Fifteen year olds at risk of parasuicide or suicide: how can we identify them in general practice?', *Family Practice*, vol. 19, no. 5, October 2002, pp. 461-465.

[47]Australian Consortium for Classification Development, International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM).

[48] Australian Government, *National Standards for Mental Health Services*, Canberra, 2010, p. 40.

[49] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 12.

[50] Department of Health, Clinical Risk Assessment and Management in Western Australian Mental Health Services, Government of Western Australia, Perth, 2008, p. 8.

[51] Department of Health, *Principles and Best Practice for the Care of People Who May Be Suicidal*, Government of Western Australia, Perth, 2017, p.2.

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thousand episodes of care or hospital admissions; and secondly, there is no set of risk factors that can accurately predict suicide in the individual patient.

… the actuarial approach, does not provide clinicians with the means to predict the risk of suicide in an individual patient. In fact, the vast majority (97%) of people assessed as being at high risk do not … [die by] suicide, while the majority of suicides (60%) occur in people assessed as being at low risk.[52]

Accordingly, in recent years, there has been a shift in the conceptualisation of 'risk of suicide' away from risk prediction, towards a prevention or recovery-focused approach that considers, over time relevant:

- population or environmental risk factors;

- historical risk factors, such as previous attempts or self-harming behaviour;

- proximal or imminent risk factors, such as a person's current mental state or suicidal intent; and

- changeable or foreseeable risks.[53]

In Western Australia, both the Department of Health and Department of Education utilise the concept of ongoing risk assessment for suicidal and self-harming behaviours to inform their 'understanding of the current situation and plan immediate and ongoing support needs'[54], as summarised by the Department of Health:

A recovery-focus in the clinical care of people who may be suicidal necessitates a shift in the current approach from clinicians managing risk to one that promotes safety and recovery; founded on shared understanding, shared decision-making and shared responsibility for safety. In promoting this approach to safety, establishing a therapeutic alliance is central and requires:

"… open, honest and transparent relationships where each understands the other's perspective and constraints and where the shared goal is one of promoting recovery and self-determination."

Essentially, the clinical assessment and care of people who may be suicidal requires meaningful collaboration with each individual, their family and personal support person, and other agencies involved in their care.[55]

Similarly, the Department of Education highlights that the 'risk of suicide is dynamic and can change rapidly. Risk assessments are limited to a 'snapshot' of presenting issues

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[52] Department of Health, *Principles and Best Practice for the Care of People Who May Be Suicidal*, Government of Western Australia, Perth, 2017, p 2 - 3.
[53] See for example Pisani M, Murrie D and Silverman M, 'Reformulating Suicide Risk Formulation: From Prediction to Prevention', *Academic Psychiatry*, vol. 40(4), August 2016, p. 623-629; Pettit J, Buitron V and Green KL, 'Assessment and Management of Suicide Risk in Children and Adolescents', *Cognitive and Behavioral Practice,* vol. 25(4), November 2018, p. 480-472; Brodsky BS, Spruch-Feiner A and Stanley B, 'The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care', *Frontiers in Psychology* vol. 9 (33), February 2018, doi: 10.3389/fpsyt.2018.00033.
[54] Department of Education, School Response and Planning Guidelines for Students with Suicidal Behavior and Non-Suicidal Self Injury, Government of Western Australia, Perth, 2018, p. 27.
[55] Department of Health, *Principles and Best Practice for the Care of People Who May Be Suicidal*, Government of Western Australia, Perth, 2017, p.2.

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which are sensitive to triggers in the environment as well as current individual presentation.'[56]

Recent Australian research supports this conceptualisation of risk and shift in focus from prediction to a broader 'needs based approach'[57] consistent with international evidence indicating that 'most people who die by suicide have not previously been in contact with mental health services.'[58] Consequentially, international best practice has also shifted in recognition that risk assessments for children and young people with self-harming or suicidal behaviour are inextricably linked to broader assessments of their needs, strengths … wider circumstances; and functioning',[59] requiring a unified cross-governmental and cross-sectoral approach underpinned by:

> … [an] emphasis … on a collaborative assessment of risk, needs, and strengths, which engages a child or engages a child or young person in a personally meaningful dialogue that helps them to consider their difficulties, the context in which these difficulties arise, and the resources available to help keep them safe. … [An] assessment of risk, needs and strengths is not a stand-alone activity. To be most helpful, it should be combined with some therapeutic strategies .... This can include, for example, safety planning, sharing plans with others, reducing access to lethal means and providing the best available evidence-based treatment to meet the needs of a child or young person. …
>
> The assessment of children and young people presenting with self-harm should include consideration of their history, family background and context [including their social situation and child protection issues].[60]

'Collaboration' in this context, refers to the ability to engage children and young people in the assessment process, including the development of 'trusting working relationships … [and] a shared understanding' of the 'past and current circumstances that are contributing to a child's or young person's difficulties and distress'[61] with:

- the child or young person;

- 'primary carers (e.g. parents, foster parents, residential childcare staff)';[62]

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[56] Department of Education, School Response and Planning Guidelines for Students with Suicidal Behavior and Non-Suicidal Self Injury, Government of Western Australia, Perth, 2018, p. 27.
[57] Large MM, Ryan CJ, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? BMJ. 2017;359
[58] Appleby L, Shaw J, Amos T, McDonnell R, Harris C, McCann K, et al. Suicide within 12 months of contact with mental health services: national clinical survey. BMJ. 1999;318:1235; Hamdi E, Price S, Qassem T, Amin Y, Jones D. Suicides not in contact with mental health services: Risk indicators and determinants of referral. Journal of Mental Health. 2008;17:398-409.
[59] National Collaborating Centre for Mental Health, Self-harm and Suicide Prevention Competence Framework: Competences for work with children and young people – Assessment, formulation, engagement and planning competences, University College London, October 2018, accessed 20 February 2020, <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self>.
[60] National Collaborating Centre for Mental Health, *Self-harm and Suicide Prevention Competence Framework*, University College London, October 2018.
[61] National Collaborating Centre for Mental Health, Self-harm and Suicide Prevention Competence Framework: Competences for work with children and young people – Assessment, formulation, engagement and planning competences, University College London, October 2018.
[62] National Collaborating Centre for Mental Health, Self-harm and Suicide Prevention Competence Framework: Competences for work with children and young people – Assessment, formulation, engagement and planning competences, University College London, October 2018.

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- the person with legal 'parental rights and responsibilities (e.g. parent, family member, carer, [or government] … department)';[63] and

- 'professionals and agencies involved with a child or young person (e.g. social work, youth justice)'.[64]

Ordinarily, this best-practice approach to collaborative and holistic assessment will include identification and assessment of the history of a child or young person's self-harming or suicidal behaviours including previous contacts with health, legal and other services; their educational history, strengths, interests and difficulties; family history; current or historical experiences of statutory care and placements; social and cultural supports and stresses and child protection concerns. However, the scope of any individual assessment is a matter of professional judgement, as:

> Where a child or young person is acutely distressed and/or judged to be at high risk of self-harm or suicide then this will need to be the focus, with a more detailed and/or broader assessment taking place once the person's immediate safety needs are appropriately contained.[65]

In Western Australia, suicide risk assessment occurs in a range of settings, including by general practitioners, nurses, psychiatrists, psychologists, social workers, counsellors and other mental health professionals. However, there is no shared definition of 'risk' or framework for working with children and young people with self-harming or suicidal behaviours that applies across government and non-government services including mental health, health, schools, TAFEs, universities, corrections, family support, child protection, community development, and other social services.

Accordingly, in this report we use the word 'risk' in a range of contexts, including the population-level risk factors associated with suicide, the fluctuating and dynamic likelihood of harm to a child or young person arising from suicidal or self-harming behaviours at a given point in time, and other risks to the safety, wellbeing and development experienced by the 115 children and young people who died by suicide, discussed in the remainder of this Chapter.

1.2   Explanations of suicide by children and young people

There is no simple explanation for suicide, as it occurs within a complex context of inter-related biological, psychological, social and environmental factors.[66] However, theoretical models are useful in understanding the reasons why children and young people die by suicide, as well as in designing programs and services to meet the needs of vulnerable children and young people who are at risk of suicide.

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[63] National Collaborating Centre for Mental Health, Self-harm and Suicide Prevention Competence Framework: Competences for work with children and young people – Assessment, formulation, engagement and planning competences, University College London, October 2018.
[64] National Collaborating Centre for Mental Health, Self-harm and Suicide Prevention Competence Framework: Competences for work with children and young people – Assessment, formulation, engagement and planning competences, University College London, October 2018.
[65] National Collaborating Centre for Mental Health, Self-harm and Suicide Prevention Competence Framework: Competences for work with children and young people – Assessment, formulation, engagement and planning competences, University College London, October 2018, <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self>.
[66] Mendoza J and Rosenberg S, *Suicide and Suicide Prevention in Australia: Breaking the Silence,* Lifeline Australia and Suicide Prevention Australia, 2010, p. 54.

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Broadly, these models fall into three overlapping categories:

- **Medical or biological theory**: (also known as the biomedical model[67]) is the theory that mental ill-health arises from a person's genetics or chemical imbalances in the brain and can be classified according to ICD-10 codes and the Diagnostic and Statistical Manual of Mental Disorders.

- **Psychological theories**: attempt to explain child and adolescent mental health based on cognitive and emotional factors, primarily through attachment theory. Attachment theory suggests that an infant's social and emotional interaction with their caregiver is internalised and shapes the infant's future cognitive development, emotional regulation, exploratory play, other behaviour and pro-social orientation towards others.[68]

  - Secure attachment builds 'mental models of a secure self, caring parents and a kind world',[69] internalising feelings of safety for a child;

  - Insecure attachment in infancy 'can affect mental well-being or predispose towards mental disorder many years or even decades later';[70] and

  - Disorganised attachment, strongly associated with experiences of child maltreatment, leads to the internalisation of 'an incoherent … model of self and others, together with the inability to clearly signal distress' and is linked to the development of psychopathology, externalising behaviour, mental-ill health and dissociative symptoms later in life.[71]

- **Systems, social and environmental theories**: suggest that the combined impact of contextual factors including parent-child and sibling relationships, family stressors, economic disadvantage, and other stressful or adverse childhood experiences, offer explanations for a child or young person's mental health.[72]

Recent models of suicide theory 'specifically hypothesize that the factors leading to the development of suicidal thinking are distinct from those that govern behavioural enaction, i.e. attempting or dying by suicide'[73] and therefore may require separate, but related, policy responses.

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[67] Deacon B, 'The biomedical model of mental disorder: A critical analysis of its validity, utility and effects on psychotherapy research', *Clinical Psychology Review*, vol. 33, 2013, pp. 846-861.

[68] World Health Organization, The importance of caregiver-child interactions for the survival and healthy development of young children: A Review, Geneva, 2004, p. 25; McLean S, Children's attachment needs in the context of out-of-home care, Child Family Community Australia, Melbourne, November 2016, p. 3.

[69] Centre for Parenting and Research, Department of Community Services, *Key messages from research: The importance of attachment in the lives of foster children*, Government of New South Wales, Sydney, July 2006, p. 5.

[70] World Health Organization, Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors – Background Paper by WHO Secretariat for the Development of a Comprehensive Mental Health Action Plan, WHO Department of Mental Health and Substance Abuse, Geneva, Switzerland, August 2012, p. 2.

[71] McLean S, *Children's attachment needs in the context of out-of-home care*, Child Family Community Australia, Melbourne, November 2016, p. 4.

[72] World Health Organization and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health*, WHO, Geneva, Switzerland, 2014; Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 7.

[73] O'Connor R and Kirtley O, 'The integrated motivational-volitional model of suicidal behaviour', *Philosophical transactions of the Royal Society of London, Series B, Biological Sciences*, vol. 373(1754):20170268, 2018, doi:10.1098/rstb.2017.0268.

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Since the 2014 Investigation there has been growing recognition of the importance of recognising that the 'risk and protective factors' frameworks often used to assess and understand suicide risk in adults are models:

> … developed for population level understandings rather than understanding the specific circumstances related to an individual child.[74]

The research literature notes that, for many children and young people exhibiting suicidal ideation or behaviours, suicide is 'often seen as a solution to intolerable overwhelming feelings rather than an explicit wish to die [and providing] … a sense of control over feelings of helplessness'.[75]

The research literature identifies that there are significant differences between suicide attempts by children and young people, as compared to the adult population, namely:

> Adolescents used significantly more over-the-counter medicines. Adults were significantly more certain of the possible fatal outcome of their attempt and had a significantly more severe intention when harming themselves. Individuals appear to use the methods that are available to them to attempt suicide. Adolescents may display more impulsive and less lethal directed behavior than adults or, alternatively, they are more frequently admitted for less severe attempts.[76]

Similarly, given the distinct differences between children and young people, it is also now suggested that:

> Like deaths by suicide in adolescents and adults, [suicide by children] is complex and multifactorial, with no one factor able to account entirely for the death. As the numbers of deaths are low, research is scant and with small numbers of case studies to drawn upon, evidence is not solid. Efforts to extrapolate from what is known about adolescent suicide is not accurate or helpful as children and adolescents differ in relation to physical, sexual, cognitive and social development.[77]

Accordingly, the research literature identifies that existing population-level models used to understand suicidality in adults may not be the best fit in understanding suicide by children and young people, because:

> Implicit assumptions are often made that the pathways to suicide for young people, including associated risk factors, are similar to those for adults. This approach inhibits the development of a systematic and effective response to young people experiencing suicidal behaviours.[78]

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[74]headspace School Support, *Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary*, headspace National Youth Mental Health Foundation, Melbourne, 2017, p. 5.
[75]Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 17.
[76]Parellada M et al, 'Is attempted suicide different in adolescent and adults?', *Psychiatry Research,* vol. 157, 2008, pp. 131-137.
[77]headspace, *Understanding suicide, suicide attempts and self-harm in primary school aged children*, viewed 28 February 2019, https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf?>, p. 1.
[78]BoysTown, *Preventing Suicide by Young People: Discussion Paper*, BoysTown and Kids Helpline, October 2015, p. 1.

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A recent study of 316 young people (under 20) who died by suicide in the United Kingdom[79] identified that distress in young people that may otherwise be regarded as 'transient or trivial' by adults can, in fact, present a serious stress and risk to a minority of vulnerable young people:

> The circumstances that lead to suicide in young people often appear to follow a pattern of cumulative risk, with traumatic experiences in early life, a build up of adversity and high risk behaviours [such as excessive alcohol and illicit drug use, or a diagnosis of mental illness] in adolescence and early adulthood, and a 'final straw' event [such as academic problems, family problems, relationship breakups, workplace problems or housing instability]. This event may not seem severe to others, making it hard for professionals and families to recognise suicide risk unless the combination of past and present problems is taken into account.[80]

Additionally, emerging research from the United States comparing the 'individual characteristics and precipitating circumstances among [87] children [aged 5 to 11 years] and [606] early adolescents [aged 12 to 14 years] who died by suicide'[81] suggests that traditional suicide prevention strategies based on identifying and treating depression may have less relevance to preventing suicide by children and young people, who may be more likely 'influenced by impulsive responding'. This study also relevantly found:

> … higher rates of depression … in early adolescents who died by suicide compared with children who died by suicide. This finding is consistent with earlier research demonstrating depressive psychopathology to be more common in older versus younger adolescent suicide decedents. …
>
> Relationship problems (e.g. arguments) were the most common precipitating circumstance observed in both childhood and early adolescent decedents, but the specific types of relationship problems differed along development lines. Compared to early adolescents who died by suicide, children who died by suicide were more likely to have relationship problems with family members and friends, whereas boyfriend/girlfriend problems were specific to early adolescents who died by suicide. …
>
> Taken together with previous studies, there appears to be justification for future research examining whether a developmental progression of vulnerability to suicide exists that is more prominently influenced by impulsive responding in younger children and by depressed mood and emotional distress with increasing age into adolescence and young adulthood. This is not to say that impulsivity is not a relevant vulnerability to suicide across the life span, but rather raises the question as to whether impulsive responding may be a more relevant vulnerability to suicide in childhood compared with adolescence, where it remains a marker of risk.[82]

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[79] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people*, University of Manchester, Manchester, July 2017, p. 21.

[80] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people*, University of Manchester, Manchester, July 2017, p. 21.

[81] Sheftall A H et al, 'Suicide in Elementary School-Aged Children and Early Adolescents', *Journal of the American Academy of Pediatrics*, vol. 138, no. 4, October 2016: e20160436; headspace School Support, *Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary*, headspace National Youth Mental Health Foundation, Melbourne, 2017, p. 5.

[82] Sheftall AH et al, 'Suicide in Elementary School-Aged Children and Early Adolescents', *Journal of the American Academy of Pediatrics*, vol. 138, no. 4, October 2016: e20160436

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In both of these recent wide-scale United States and United Kingdom studies, the proportion of children and early adolescents and young people who died by suicide that had a current mental health issue or had been diagnosed with a mental illness (being 34.6 per cent of children and 34.8 per cent of early adolescents in the United States study and 20 per cent of young people aged under 20 in the United Kingdom study) was lower than population level estimates of mental illness as a risk factor for suicide. For example, research cited in the Western Australian Suicide Prevention Strategy *Suicide Prevention 2020: Together We Can Save Lives* states that:

> The most common and significant risk factor associated with suicide is mental illness. Previous Western Australian coronial data found that 35% of men and 60% of women who completed suicide had suffered from a diagnosed psychiatric disorder in the preceding 12 months. The observations of family and friends of those who completed suicide indicate that 57% of men and 66% of women exhibited symptoms of depression in the three months preceding their deaths. …

> More recent research highlights that mental illness is present in up to 90% of people who die by suicide in higher socio-economic countries.[83]

A recent Australian comparative study based on data from the Queensland Suicide Registry found that suicide by:

- children (10 to 14 years), was 'characterised by higher prevalence of family conflicts, school related problems and suicides in social groups';

- young adults (20 to 24 years), involved a 'significantly higher prevalence of psychiatric disorders and were much more impacted by relationship problems'; and

- young people (15 to 19 years), demonstrated 'characteristics … [that] fell in between the other age groups.'[84]

Accordingly, given these differences in suicide by children, young people and adults, the remainder of this chapter outlines some of the theoretical models from the research literature that offer explanations of suicide by children and young people.

1.2.1   Risk and resilience model of child and adolescent mental health

The risk and resilience model combines elements of the medical, psychological and social theoretical models of suicide and presents three areas of risk, together with resilience factors (Figure 2). These risk and resilience factors can be used by public health service providers and policy makers to:

- understand the probability of, and 'onset and persistence of childhood and adolescent problems';[85] and

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[83]Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Government of Western Australia, Perth, 2015, p. 16.
[84]Kolves K and De Leo D, 'Child, Adolescent and Young Adult Suicides: A Comparison Based on the Queensland Suicide Registry', *Journal of Child and Adolescent Behavior*, vol. 209, no. 3, May 2015, doi:10.4172/2375-4494.1000209.
[85]Jenson JM and Fraser MW, 'Chapter 1: A Risk and Resilience Framework for Child, Youth, and Family Policy', in *Social Policy for Children and Families: A risk and Resilience Perspective* (3rd ed.), SAGE Publications, Thousand Oaks, California, February 2015, pp. 5-21.

- interpret a child's or young person's observable behaviours in the context of possible mental health issues or suicidal behaviour and the child or young person's interaction with their school, peer, family and community environment.

Figure 2: Risk and resilience model of child and adolescent mental health

Risk Factors			Resilience/ Protective Factors
Environmental/ Contextual	Family	Child/Young Person	
• Socioeconomic disadvantage • Homelessness • Disaster • Discrimination • Violence in the community • Being Aboriginal or a refugee/asylum seeker • Other significant life events • Living in care of child protection authorities • Living in a rural or remote location • Availability of means • Inappropriate media reporting	• Early attachment/ nurturing problems • Parental conflict • Family breakdown • Inconsistent/ unclear discipline • Hostile and/or rejecting relationships • Significant adults not adapting to the child's changing developmental needs • Physical, emotional, sexual abuse • Parental mental and/or physical illness • Parental criminality • Grief and loss, bereavement issues relating to family members and/or friends • Family history of self-harm, suicidal ideation, suicide attempts or death by suicide	• Genetic influences • Low IQ or learning difficulties • Developmental delay • Communication difficulties • Gender identity conflict • Chronic physical illness • Neurological disorder • Academic failure/ poor school attendance • Low self-esteem • Depression • Substance use • Conduct disorder, schizophrenia, anxiety disorders, personality disorders, eating disorders • Previous self-harm, suicidal ideation or suicide attempt • Impulsivity, poor problem solving, hopelessness or self-hatred	• Secure attachments • Self-esteem • Social skills • Familial compassion and warmth • A stable family environment • Social support systems that encourage personal development and coping skills • A skill or talent • Awareness of and access to clinical and health services • A sense of safety at school and in the community

Source: Pearce (2004)[86] and Orygen (2017)[87]

The risk and resilience model echoes the research literature relating to adult suicide prevention cited in the 2014 Investigation, including Bycroft's model, which identifies a pathway from risk factors, warning signs and tipping points, to indicators of 'imminent risk' of suicide (together, referred to as **factors associated with suicide**) as summarised in Figure 3:

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[86]Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, pp. 8-9, citing Pearce J, 'Emotional Disorders in Young People', in Aggleton P, Hurry J and Warwick I (eds) *Young People and Mental Health*, Wiley-Blackwell, Chichester, 2004, pp. 47-72.
[87]Orygen, The National Centre of Excellence in Youth Mental Health, Clinical practice in depression and suicide: Managing ongoing suicidality in young people diagnosed with Major Depressive Disorder (MDD), 2017, viewed 26 September 2018, <https://www.orygen.org.au/Education-Training/Resources-Training/Resources/Free/Clinical-Practice/Managing-suicidality-in-yp/Clinical_practice_in_depression_suicide?ext=.>, p. 3.

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Figure 3: The pathway from risk factors to the point of imminent risk

Risk Factors	Warning Signs	Tipping Point	Imminent Risk
Mental Health Issues Sex – male Family discord, violence or abuse Family history of suicide Alcohol or other substance abuse Social or geographical isolation Financial stress Bereavement	Hopelessness Feeling trapped Increasing alcohol or drug use Withdrawing from family, friends or society No reason for living, no sense of purpose in life Prior suicide attempt Uncharacteristic or impaired judgement or behaviour	Relationship ending Loss of status or respect Debilitating physical illness or accident Death or suicide of relative or friend Argument at home Being bullied or abused Media report on suicide or suicide methods	Expressed intent to die Has a plan in mind Has access to lethal means Impulsive, aggressive or anti-social behaviour

Source: Bycroft 2010[88]

The research literature suggests that some 'triggers' specific to children and young people may influence self-harming and suicidal behaviours, as follows:

Triggers influencing self-harm and suicidal behavior include:
- Bullying
- Difficulties with parental and peer relationships
- Bereavement
- Earlier abusive experiences
- Difficulties with sexuality
- Problems with ethnicity, culture, religion
- Substance misuse and low self-esteem

Contextual triggers include:
- Adverse family circumstances
- Dysfunctional relationships
- Domestic violence, poverty and parental criminality
- Time in … [child protection] authority care
- Frequent punishments
- Family transitions[89]

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[88]Mendoza J and Rosenberg S, *Suicide and Suicide Prevention in Australia: Breaking the Silence,* Lifeline Australia and Suicide Prevention Australia, 2010, p. 55, citing Bycoft, P, *Perspectives on Suicide and Suicide Prevention*, National Mental Health Summit, University of the Sunshine Coast.
[89]Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 19.

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A child or young person, their family, or medical staff may explain self-harming or suicidal behaviour as being caused by a 'triggering' event. However, the research literature identifies that most children and young people who experience 'triggers' do not necessarily self-harm or suicidal behaviour. Accordingly, care must be taken in discussing 'triggers' as a cause of suicidal behaviour in children and young people without due consideration of the broader emotional, psychological and social circumstances experienced by a particular child or young person:

> The notion of a trigger as an explanation often leads to a minimising of the level of seriousness surrounding the suicide attempt and is never about the stated reason. The reason identified is perhaps more of a rationalisation of the event rather than an explanation and it may be a frightening prospect for all concerned to even consider a serious mental disturbance. This is a very important point to bear in mind and is the key to understanding suicidal ideation. For example not all individuals who have arguments and fail exams make attempts on their lives, therefore those that do so for those reasons given are responding to a trigger (the argument, exam failure) to much deeper underlying intolerable problems. Suicide and suicidal ideation almost always take place within the context of relationships, which is the challenge to explore and understand. There is an emotional and psychological component. Exceptions are those responding to delusions or hallucinations linked to drug misuse or psychosis. Use of triggers as an explanation can lead to collusion and denial of the seriousness of the event, not only by family members but clinical staff also, and therefore it is highly risky in itself not to take the attempt seriously.[90]

1.2.2 Interpersonal Theory

In the 2014 Investigation, the Office noted the 2005 publication of Joiner's interpersonal-psychosocial theory of suicidal behaviour (**Interpersonal Theory**), which identified that feelings of isolation and being a burden to others, combined with a desire to die and the acquired 'ability to enact lethal self-injury' act as 'conditions' for suicide.[91]

The Interpersonal Theory is a psychological model for explaining suicide, which proposes that suicidal behaviour emerges from a combination of three factors, that clinicians should be aware of when assessing suicide risk and planning therapeutic interventions, namely:

- thwarted belongingness ('I am alone', 'I feel disconnected from others', 'I have no one to turn to and I don't support others'[92]);

- perceived burdensomeness ('I am a burden', 'I hate myself'[93], 'My death will be worth more than my life to family, friends, society, etc'[94]); and

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[90]Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 19.
[91]Joiner T, *Why People Die by Suicide*, Harvard University Press, Cambridge, Massachusetts, 2005.
[92]Van Orden K et al, 'The Interpersonal Theory of Suicide', *Psychological review*, vol. 11, no. 2, 2010, pp. 575-600, doi: 10.1037/a0018697.
[93]Van Orden K et al, 'The Interpersonal Theory of Suicide', *Psychological review*, vol. 11, no. 2, 2010, pp. 575-600, doi: 10.1037/a0018697.
[94]Joiner T, 'The Interpersonal-Psychological Theory of Suicidal Behavior: Current Empirical Status', *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 21 February 2019
<https://www.apa.org/science/about/psa/2009/06/sci-brief>.

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- capability for suicide ('I am not afraid to die'[95]) which may comprise anger[96] and 'reduced fear of death and increased tolerance for physical pain'.[97]

Figure 4: The Interpersonal Theory of Suicide
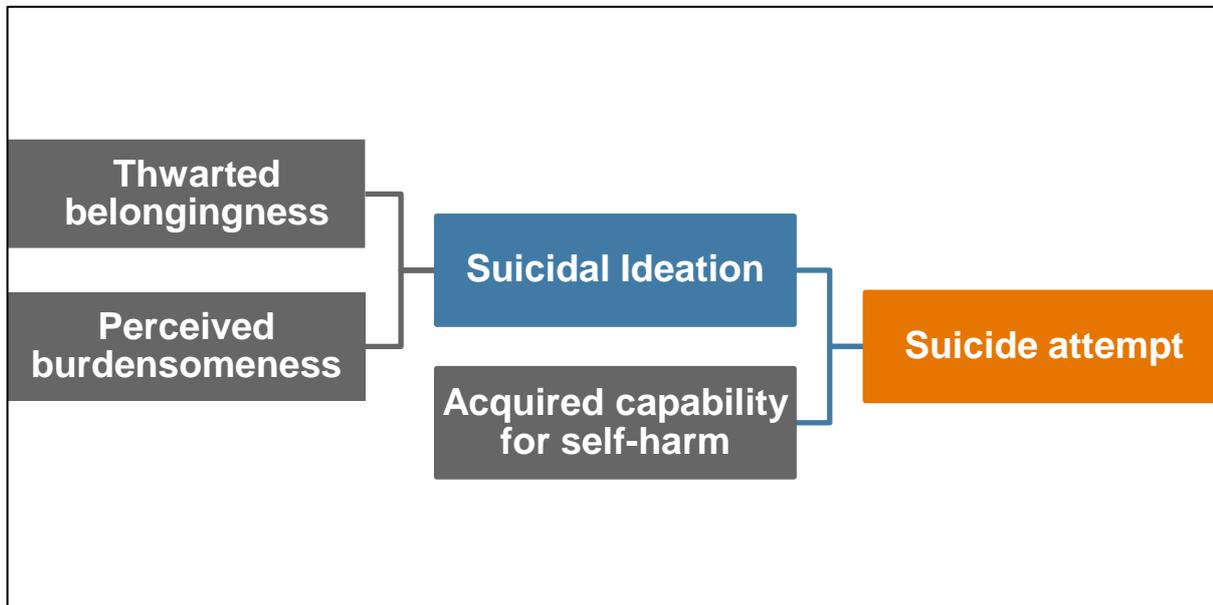
Source: Joiner (2005)[98]

The Interpersonal Theory attempts to reconcile the 'gap' between earlier theories of suicide and empirical data, by answering the question 'If emotional pain, hopelessness, emotional dysregulation, or any variable is crucial in suicide, how then to explain the fact that most people with any one of these variables do not die by or even attempt suicide?'[99] Joiner argues that earlier models of suicide:

> … assume that suicide is multifactorially caused such that suicidal ideation results from the fewest number of co-occurring risk factors, suicide attempts from a greater number, and death by suicide from the co-occurrence of the greatest number. These models also assume that risk for suicide is elevated due to greater risk for suicidal desire, and perhaps, increasingly severe forms of suicidal desire. These assumptions remain unchallenged by current theories and models of suicide. In contract, according to the Interpersonal Theory, desire to die by suicide is not sufficient for lethal suicidal behaviour to result because, simply put, dying by suicide is not an easy thing to do. …

> According to the theory, it is possible to acquire the capability for suicide, which is composed of both increased physical pain tolerance and reduced fear of death, through habituation and activation of opponent processes, in response to repeated exposure to physically painful and/or fear-inducing experiences. In other words, through repeated practice and exposure, an individual can habituate to the physically painful and fearful aspects of self-

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[95]Ludwig B, et al., 'The life span model of suicide and its neurobiological foundation', *Frontiers in Neuroscience*, vol. 11, no. 74, February 2017, doi: 10.3389/fnins.2017.00074.
[96]Hawkins K et al, 'An examination of the relationship between anger and suicide risk through the lens of the interpersonal theory of suicide', *Journal of Psychiatric Research*, vol. 50, 2014, pp. 59-65.
[97]O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[98]O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[99]Joiner T, *Why People Die by Suicide*, Harvard University Press, Cambridge, Massachusetts, 2005, p. 46.

harm, making it possible for him or her to engage in increasingly painful, physically damaging, and lethal forms of self-harm.[100]

In the time since the 2014 Investigation, the research literature has tested the application of the Interpersonal Theory in practice, including in populations of young people, and identified that:

- 'there is some support for the theory in adolescence, particularly with regard to its most novel component, the association between acquired capability and suicide attempt';[101]

- depression was the best single predictor of suicidal ideation;[102]

- 'thwarted belongingness' acts in different ways dependent upon whether it relates to parents or peers, indicating that young people with a low sense of belongingness to parents and a high sense of burdensomeness are at significantly higher risk of suicidal ideation (unlike those young people reporting only low peer belongingness); [103]

- in one study, young people living in an out-of-home placement as a result of adjudicated juvenile offending proceedings, unexpectedly reported less suicidal ideation than those offenders who remained in the home;[104]

- there may be two separate pathways for suicidal behaviour in young people, namely, an internalising psychopathology and, secondly, from previous self-harming behaviours related to poor impulse control and risk taking behaviours;[105]

- measures of the 'key IPTS [Interpersonal Theory] constructs of thwarted belongingness, perceived burdensomeness, acquired capability for suicide, as well as depression severity, hopelessness, and severity of suicidal symptoms' offered 'strong, albeit preliminary' support of the Interpersonal Theory and that 'Assessment of IPTS [Interpersonal Theory] constructs may be useful in determining persistent risk for suicide attempt' for adolescents on an inpatient psychiatric unit;[106] and

- the capability for suicide may have a substantial genetic component, and for this reason, 'belongingness and burdensomeness may be more appropriate targets for

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[100] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[101] Steward S et al, 'The Validity of the Interpersonal Theory of Suicide in Adolescence: A Review', *Journal of Clinical Child and Adolescent Psychology*, vol. 46, no. 3, April 2015, doi: 10.1080/15374416.2015.1020542, pp. 437-449.
[102] Barzilay S et al, 'The interpersonal theory of suicide and adolescent suicidal behaviour', *Journal of Affective Disorders*, no.185, May 2015, doi: 10.1016/j.jad.2015.04.047, pp. 68-74.
[103] Barzilay S et al, 'The interpersonal theory of suicide and adolescent suicidal behaviour', *Journal of Affective Disorders*, no.185, May 2015, doi: 10.1016/j.jad.2015.04.047, pp. 68-74.
[104] Kretschmar J and Flannery D, 'Displacement and suicide risk for juvenile-justice involved youth with mental health issues', *Journal of Clinical and Adolescent Psychology*, vol. 40, no. 6, 2011, doi: 10.1080/15374416.2011.614587, pp. 797-806.
[105] Barzilay S et al, 'The interpersonal theory of suicide and adolescent suicidal behaviour', *Journal of Affective Disorders*, no.185, May 2015, doi: 10.1016/j.jad.2015.04.047, pp. 68-74.
[106] Horton S, Hughes J, King J et al, 'Preliminary Examination of the Interpersonal Psychological Theory of Suicide in an Adolescent Clinical Sample', *Journal of Abnormal Child Psychology*, vol. 44, no. 6, August 2016, doi: 10.1007/s10802-015-0109-5, pp. 1133-1144.

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clinical intervention than acquired capability as these factors may be more malleable or amenable to change.'[107]

1.2.3 The Integrated Motivational-Volitional Model of Suicidal Behaviour

The recently developed Integrated Motivational-Volitional Model of Suicidal Behaviour (**IMV**), is a comprehensive model of suicidal and self-harming behaviour, combining elements from the biological, psychological, environmental and cultural theories.[108] It aims to:

> … synthesize the extant evidence [on the interplay of biological, clinical, psychological, social, cultural risk and protective factors associated with suicide] into a detailed theoretical framework that could make predictions about the factors that lead people to think about suicide and those factors which govern whether people act on their thoughts, i.e. attempt suicide/die by suicide.[109]

The IMV proposes three phases that describe the pathway from suicidal ideation to suicidal behaviour, (shown in Figure 5) namely:

- 'The pre-motivational phase: background factors and triggering events';

- 'The motivational phase: emergence of suicidal ideation'; and

- 'The volitional phase: from suicidal ideation to suicide attempts/suicide'.[110]

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[107] Smith A et al, 'An examination of environmental and genetic contributions to the determinants of suicidal behaviour among male twins', *Psychiatry Research*, vol. 197, no. 1-2, March 2012, doi: 10.1016/j.psychres.2012.01.010, pp. 60-65.
[108] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[109] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[110] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.

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Figure 5: The Integrated Motivational-Volitional Model of Suicidal Behaviour
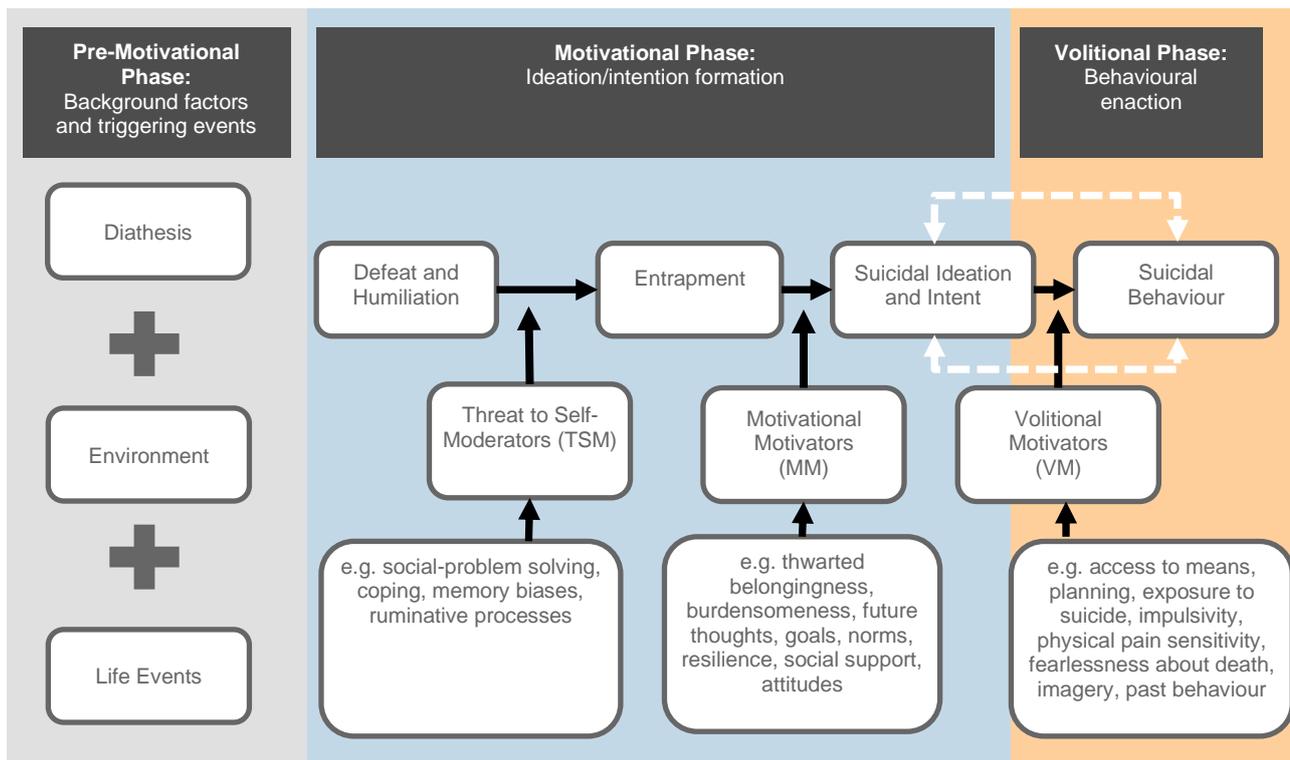
Source: O'Connor and Kirtley (2018)[111]

The central premise of the IMV is that the factors associated with the development of mental ill-health and suicidal ideation are separate and distinct from the factors which cause a person to transition from suicidal ideation to suicidal behaviour. The key premises of the IMV are as follows:

	Premise
1	Vulnerability factors combined with stressful life events (including early life adversity) provide the backdrop for the development of suicidal ideation.
2	The presence of pre-motivational vulnerability factors (e.g. socially prescribed perfectionism) increases the sensitivity to signals of defeat.
3	Defeat/humiliation and entrapment are the key drivers for the emergence of suicidal ideation.
4	Entrapment is the bridge between defeat and suicidal ideation.
5	Volitional-phase factors govern the transition from ideation/intent to suicidal behavior.
6	Individuals with a suicide attempt or self-harm history will exhibit higher levels of motivational and volitional-phase variables than those without a history.
7	Distress is higher in those who engage in repeated suicidal behaviour and over time, and intention is translated into behaviour with increasing rapidity.[112]

Source: O'Connor and Kirtley (2018)[113]

[111] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[112] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[113] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.

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Further, the IMV model specifies '8 Volitional Factors' or 'volitional moderators' that 'govern the transition from suicidal ideation/intent to enaction',[114] as follows:

Figure 6: IMV Model – Volitional Moderators

Access to means
Does this individual have ready access to likely means of suicide?

Planning (if-then plans)
Has individual formulated a plan for suicide?

Exposure to suicide or suicidal behaviour
Has a family member/friend engaged in suicidal behaviour?

Impulsivity
Does individual tend to act impulsively/on spur of moment?

Physical pain sensitivity/endurance
Has the individual high (increased) physical pain endurance?

Fearlessness about death
Is individual fearful about death? Has this changed?

Mental Imagery
Does individual describe visualizing dying/after death?

Past suicidal behaviour
Does the individual have history of suicide attempts or self-harm?

Suicidal ideation and intent

Suicidal behaviour

The dotted line between 'suicidal ideation and intent' and 'suicidal behaviour' reflects 'the dynamic and (for some) cyclical relationship between suicidal ideation and repeat suicide attempts'.

Source: O'Connor and Kirtley (2018)[115]

Empirical testing of the IMV model supports the use of the IMV model as a framework for use in developing effective suicide prevention interventions and initiatives. For example, testing of in adolescent clinical samples has found that:

> … the basic premises of the model also apply to self-harm, irrespective of motive. For example, volitional-phase moderators have been shown to distinguish between adolescents who have thought about self-harm and those who have self-harmed (for a wide variety of motives). …

> A recent study from a population based birth cohort of 4772 adolescents also found that exposure to the self-harm of others (alongside psychiatric disorder)

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[114] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[115] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.

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was the factor that most clearly differentiated those who had attempted suicide from those who had thought about suicide without making an attempt.[116]

Researchers have used the results of this and similar studies testing other elements of the IMV model (including the Scottish Wellbeing Study of 3,508 young people) to inform the development of clinical interventions including:

- a 'volitional help sheet' (a brief intervention tool);[117]

- a new post-suicide attempt safety planning and telephone support service random control trial;[118]

- the English National Health Service and National Collaborating Centre for Mental Health's *Self-harm and Suicide Prevention Competence Framework: Children and Young People,* which emphasises the need for health professionals to understand the motivational (including the importance of entrapment) and volitional phases of suicide risk.[119]

The IMV model has been promoted by Orygen as a tool for case formulation by clinicians when treating young people who present with suicidal ideation and/or self-harming behaviours.[120]

1.2.4 Stress-Vulnerability model

The Stress-Vulnerability model shown in Figure 7 below, suggests that both genetic and developmental vulnerability to mental health disorders, and stress caused by challenges faced during a person's life, are able to be influenced by other factors such as coping skills, social support and meaningful activities.

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[116] O'Connor R and Kirtley O, 'The integrated-motivational-volitional model of suicidal behaviour', *Philosophical Transactions of The Royal Society of Biological Sciences*, vol. 373, no. 1754, July 2018, doi: 10.1098/rstb.2017.0268.
[117] Suicidal Behaviour Research Lab, *The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour*, November 2018, viewed 21 February 2019, <http://www.suicideresearch.info/the-imv>.
[118] Suicidal Behaviour Research Lab, *The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour*, November 2018, viewed 21 February 2019, <http://www.suicideresearch.info/the-imv>.
[119] Suicidal Behaviour Research Lab, *The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour*, November 2018, viewed 21 February 2019, <http://www.suicideresearch.info/the-imv>; National Collaborating Centre for Mental Health, *Self-harm and Suicide Prevention Competence Framework: Children and Young People,* October 2018, viewed 21 February 2019, <https://www.ucl.ac.uk/pals/sites/pals/files/self-harm_and_suicide_prevention_competence_framework_-_children_and_young_8th_oct_18.pdf>; University College London, *Competences for work with children and young people: Knowledge specific to work with children and young people and of issues related to self-harm and suicide*, October 2018, viewed 21 February 2019, <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self>.
[120] Hetrick S, *Suicide and Self-Harm in Adolescents*, presentation to the New Zealand Early Intervention in Psychosis Training Forum, Christchurch, November 2017, viewed 26 September 2018, <https://www.tepou.co.nz/uploads/files/resource-assets/Sarah%20Hetrick%20-%20Suicide%20and%20self-harm%20in%20adolescents.pdf>.

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**Figure 7: The Stress-Vulnerability Model of the suicidal process and
its evolution based on the individual's vulnerability**
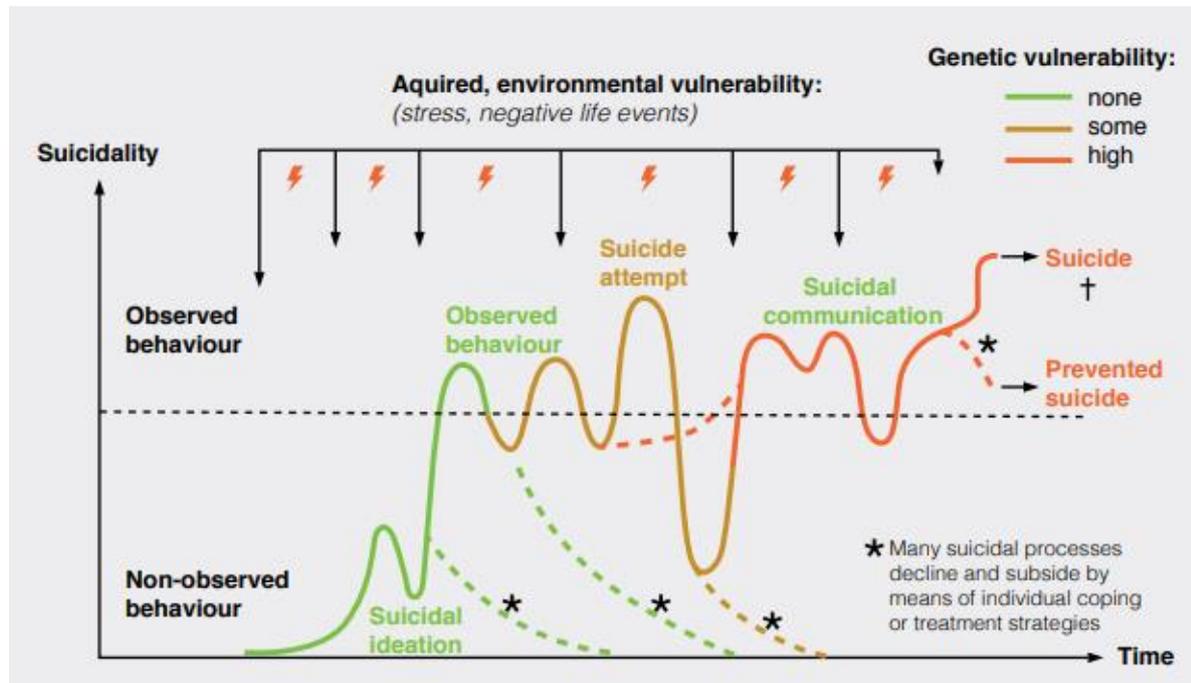
Source: headspace, citing Wasserman (2012)

The authors of the Stress-Vulnerability model suggest that suicidal behaviour is best understood as:

> … a complex process which develops over time … [and] is influenced by interacting biological, psychological, environmental and current situational factors. One of the most important components modulating the risk for suicidal behaviours as well as their prevention is a person's state of mental health and self-image.[121]

In Australia, *headspace* have suggested that this model could be applicable to children, on the basis that it encompasses the role of early traumatic life experiences, chronic illness, parental alcohol and substance misuse and other environmental factors in contributing to a child's predisposition or vulnerability to suicidal behaviour and self-harm.[122]

1.3   Children and young people with higher rates of suicide

Suicide or attempted suicide of children and young people is an unimaginably tragic issue. Losing a child or young person by suicide is a uniquely traumatic experience and for family, carers, friends, first responders and the Western Australian community generally, with often long-lasting and far-reaching effects:

> Suicide or an attempt can cause not only immense distress to individuals, but
> also vicarious trauma among the wider community (e.g. individuals … [who]

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[121] Wasserman D et al, 'The European Psychiatric Association (EPA) guidance on suicide treatment and prevention', *European Psychiatry*, vol.27, no. 2, February 2012, doi: 10.1016/j.eurpsy.2011.06.003, pp.129-141.
[122] headspace, *Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary*, viewed 5 March 2019, <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf>.

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witness/experience the impact of a suicide and are typically left at a loss, asking themselves how to help, why they didn't see the warning signs, what they could have done/said to prevent the tragedy). Those close to the person who has died will often blame themselves for the decision of the individual to take their own life. The combination of grief, guilt and remorse often remains for years.

The impact of a suicide or suicide attempt on first responders, such as police, ambulance and fire brigade, should also not be underestimated. The responses to suicide are further complicated by community stigma and perceptions of the act of suicide as a failure on the part of either the deceased (to cope) or the family (for not having intervened or prevented the suicide).[123]

The research literature identifies groups of children and young people that have relatively high rates of suicide. However, the research literature also acknowledges that:

Australia has a diverse population regionally, but also culturally and demographically. …

It should be acknowledged that some priority populations are not intrinsically more at risk of suicidal behaviour, but rather that these individuals may experience greater rates of discrimination, isolation and other forms of social exclusion which can impact on suicidal thinking and behaviour.

Others may be at increased risk of suicide due to their experiences (in childhood or adulthood), their current access to economic and social resources, their current health status and their previous exposure to suicidal behaviour.[124]

These groups include:

- **children and young people who have previously attempted suicide:** The research literature indicates that children and young people who have attempted suicide are '18 times more likely to try it again, and are 40 times more likely to die by suicide in the future'.[125]

- **children and young people who have experienced abuse or neglect:** Research indicates that abuse and neglect significantly increases the risk of attempted suicide by young people.[126] In particular those children and young people who have experienced sexual abuse may be up to eight times more likely to make repeated

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[123] Connetica, *Suicide in Australia – Key Facts*, May 2016, viewed 13 September 2018, <https://static1.squarespace.com/static/5858b2276b8f5be324ffefff/t/5898ff2f15d5dba05f6c9c9d/1486421825261/media_backgrounder_-_suicide-suicide_prevention_australia_may_24_final.pdf>, p. 2.

[124] Everymind, *Suicide Prevention – Understanding Suicide: Key facts*, Everymind, Newcastle, 2018, viewed 26 September 2018, <https://everymind.org.au/suicide-prevention/understanding-suicide/key-facts>.

[125] beyondblue, *Risk factors for suicide*, viewed 13 September 2018, <https://healthyfamilies.beyondblue.org.au/age-13/mental-health-conditions-in-young-people/suicide/risk-factors-for-suicide>.

[126] Brodsky B and Stanley B, 'Adverse childhood experiences and suicidal behavior', *Psychiatric Clinics of North America*, vol. 31, no. 2, June 2008, doi: 10.1016/j.psc.2008.02.002, pp. 223-235; Evans E, Hawton K, and Rodham K, 'Suicidal phenomena and abuse in adolescents: A review of epidemiological studies', *Child Abuse and Neglect*, vol. 29, no. 1, January 2005, doi: 10.1016/j.chiabu.2004.06.014, pp. 45-58; Miller AB et al, 'The relation between child maltreatment and adolescent suicidal behavior: A systematic review and critical examination of the literature', *Clinical Child and Family Psychology Review*, vol. 16, no. 2, June 2013, doi: 10.1007/s10567-013-0131-5, pp. 146-172; Thompson R et al, 'Adverse experiences and suicidal ideation in adolescence: Exploring the link using the LONGSCAN samples', *Psychology of Violence*, vol. 2, no. 2, April 2012, doi: 10.1037/a0027107, pp. 211-225.

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suicide attempts than those who have not experienced sexual abuse.[127] Researchers suggest that sexual abuse may be 'specifically related to suicidal behaviour because it is closely associated with feelings of shame and internal attributions of blame.'[128]

- **children and young people who have a mental health condition:** The research literature indicates mental ill-health is one of the strongest risk factors for suicide, with studies identifying that between 43 and 88.6 per cent of children and young people who die by suicide had one or more diagnosed mental health conditions.[129]

- **children and young people who know a person who died by suicide:** Research literature has shown that children and young people with a family member, other relative or caregiver, friend, or other person known to them who died by suicide are at greater risk of attempting suicide or dying by suicide.[130]

- **Aboriginal and/or Torres Strait Islander children and young people**: In Western Australia, from 2012 to 2016, the rate of suicide for Aboriginal children and young people aged five to 17 years was 18.0 per 100,000 compared to 2.0 per 100,000 for non-Aboriginal children and young people aged five to 17 years.[131]

- **children and young people living in rural and remote areas:** In Western Australia, from 2012 to 2016, the rate of suicide for children and young people aged five to 17 years residing outside the Greater Perth region was 5.8 per 100,000, compared to 2.2 per 100,000 for young people residing in the Greater Perth region.[132]

- **male children and young people residing in regional and remote areas:** In Western Australia, outside the Greater Perth region, from 2012 to 2016, the rate of suicide for males children and young people between the ages of 5 and 17 years was 3.4 per 100,000, compared to 2.7 per 100,000 for young males between the ages of 5 and 17 years.[133]

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[127] Brodsky B and Stanley B, 'Adverse childhood experiences and suicidal behavior', *Psychiatric Clinics of North America*, vol. 31, no. 2, June 2008, doi: 10.1016/j.psc.2008.02.002, pp. 223-235; Evans E, Hawton K, and Rodham K, 'Suicidal phenomena and abuse in adolescents: A review of epidemiological studies', *Child Abuse and Neglect*, vol. 29, no. 1, January 2005, doi: 10.1016/j.chiabu.2004.06.014, pp. 45-58; Miller AB et al, 'The relation between child maltreatment and adolescent suicidal behavior: A systematic review and critical examination of the literature', *Clinical Child and Family Psychology Review*, vol. 16, no. 2, June 2013, doi: 10.1007/s10567-013-0131-5, pp. 146-172.

[128] Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, May 2014, viewed 13 September 2018, <https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents>, citing Brodsky B and Stanley B, 'Adverse childhood experiences and suicidal behavior', *Psychiatric Clinics of North America*, vol. 31, no. 2, June 2008, doi: 10.1016/j.psc.2008.02.002, pp. 223-235.

[129] Rodway C et al, 'Suicide in children and young people in England: a consecutive case series', *Lancet Psychiatry*, vol. 3, no. 8, 1 August 2016, pp. 751-759; Fleischmann A et al, 'Completed Suicide and Psychiatric Diagnoses in Young People: A Critical Examination of the Evidence', *American Journal of Orthopsychiatry*, vol. 75, no. 4, 2005, pp. 676-683.

[130] De Leo D and Heller T, 'Social modelling in the transmission of suicidality', *Crisis, the Journal of Crisis Intervention and Suicide*, vol. 29, no. 1, 2008, pp. 11-19; Commission for Children and Young People and Child Guardian, *Reducing youth suicide in Queensland Discussion Paper*, Queensland Government, 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.

[131] The Australian Bureau of Statistics refers to 'Aboriginal and Torres Strait Islander peoples' and 'non-Indigenous' people.

[132] Australian Bureau of Statistics, 'Table 11.13 Intentional self-harm, Age specific death rates, 10 year age groups by sex, 2007-2016', *Causes of Death, Australia, 2016,* cat. no. *3303.0,* ABS, Canberra, September 2017.

[133] Using rates calculated from the number of deaths by suicide analysed in the 2020 investigation and Australian Bureau of Statistics, 'Table 55 Estimated Resident Population By Single Year of Age, Western Australia', *Australian Demographic Statistics*, cat. no. 3101.0, ABS, Canberra, December 2018.

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- **young people with diverse gender identity or sexuality:** The research literature indicates that same-sex attracted young people may be twice as likely to die by suicide than the general population.[134]

1.4 Factors associated with suicide

1.4.1 Child abuse and neglect

In the research literature, the terms 'child maltreatment' and 'child abuse and neglect' are often used interchangeably. However, the most common term used in Australia is 'child abuse and neglect'.

The World Health Organization's 1999 Consultation on Child Abuse Prevention defined child abuse as follows:

> Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[135]

In the research literature child abuse and neglect is commonly divided into five main types, including sexual abuse, physical abuse, neglect, exposure to family and domestic violence, and emotional (and psychological) abuse. The Office examined five forms of child abuse and neglect: sexual abuse, physical abuse, neglect, exposure to family and domestic violence, and other forms of emotional or psychological abuse.[136]

The research literature indicates that child 'abuse and neglect significantly increases the risk of suicidal ideation and attempted suicide for young people.'[137]

1.4.1.1 Sexual abuse

'Sexual abuse' is defined by the World Health Organization as:

> … the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim. [138]

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[134] King M et al., 'A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people', *BMC Psychiatry*, vol. 8, no. 70, August 2008, doi: 10.1186/1471-244X-8-70; Chakraborty A et al, 'Mental health of the non-heterosexual population of England', *British Journal of Psychiatry*, vol. 198, no. 2, February 2011,
doi: 10.1192/bjp.bp.110.082271, pp. 143-148,

[135] World Health Organization, Report of the Consultation on Child Abuse Prevention 29-21 March 1999, WHO, Geneva, Switzerland, 1999.

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

[137] Australian Government, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies Child Family Community Australia, viewed 26 September 2018,
<https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents>.

[138] World Health Organization and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A guide to taking action and generating evidence*, WHO, Geneva, Switzerland, 2006, p. 10.

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The Department of Communities has a similar definition of sexual abuse, but also notes that it includes circumstances where 'the child has been bribed, threatened, or coerced'[139] and that possible signs of sexual abuse include when a child:

- acts in a sexualised way that is inappropriate to his/her age;

- creates stories, poems or artwork about abuse;

- has pain, bleeding or swelling in his/her genital area;

- starts doing things they have grown out of such as crying a lot, bed wetting or soiling, clinging to caregiver;

- has nightmares or sudden unexplained fears; or

- has a sexually transmitted infection or is pregnant.[140]

In Western Australia, since 1 January 2009, doctors, nurses, teachers and police officers have been required by law to report all reasonable beliefs of suspected child sexual abuse to Communities.[141]

Records indicate that 31 of the 115 children and young people (27 per cent) allegedly experienced sexual abuse prior to their death.

1.4.1.2   Physical abuse

'Physical abuse' is defined by the World Health Organization as:

> The intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating. Much physical violence against children in the home is inflicted with the object of punishing.[142]

The Department of Communities similarly defines physical abuse as including 'punching, kicking, shaking or throwing, scalding/burning, strangling or leaving a child along in a car … excessive physical discipline or by being given drugs including alcohol.'[143] However, in Western Australia, under section 257 of the *Criminal Code*, corporal punishment remains legal, providing it is limited to 'such force as is reasonable under the circumstances'[144]

Physical abuse may be indicated by the following signs:

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[139] Department of Communities, Child Protection and Family Support, *Sexual Abuse*, 9 August 2012, viewed 26 September 2018, <https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Pages/Sexualabuse.aspx>.
[140] Department of Communities, Child Protection and Family Support, *Sexual Abuse*, 9 August 2012, viewed 26 September 2018, <https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Pages/Sexualabuse.aspx>.
[141] Children and Community Services Act 2004 (WA), ss. 124A and 124B.
[142] World Health Organization and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A guide to taking action and generating evidence*, WHO, Geneva, Switzerland, 2006, p. 10.
[143] Department for Child Protection and Family Support, *How do I recognize when a child is at risk of abuse or neglect?*, Government of Western Australia, viewed 27 October 2019, <https://www.dcp.wa.gov.au/ChildProtection/Documents/HowDoIRecogniseWhenAChildIsAtRiskOfAbuseOrNeglect.pdf>, p. 2.
[144] Criminal Code 1913 (WA), s. 257.

- broken bones or unexplained bruises, burns or welts in various stages of healing
- the child or young person can't explain an injury, or provides an inconsistent, vague or unlikely explanation
- parents saying that they're worried that they might harm their child
- family history of violence
- Female Genital Mutilation
- delay between being injured and getting medical help
- parents who show little concern about their child, the injury or the treatment
- frequent visits to health services with repeated injuries, illnesses or other complaints
- the child or young person seems frightened of a parent or carer, or seems afraid to go home
- the child or young person reports intentional injury by their parent or carer
- arms and legs are kept covered by clothing in hot weather
- ingestion of poisonous substances including alcohol or drugs
- the child or young person avoids physical contact (particularly with a parent or carer)[145]

Records indicate that 32 of the 115 children and young people (28 per cent) allegedly experienced physical abuse.

1.4.1.3 Neglect

Neglect is defined by the World Health Organization as including:

> … isolated incidents, as well as a pattern of failure over time on the part of a parent or other family member to provide for the development and well-being of the child – where the parent is in a position to do so – in one or more of the following areas:
>
> - health;
> - education;
> - emotional development;
> - nutrition;
> - shelter and safe living conditions.[146]

The Department of Communities takes a broader view of neglect, defining it as follows:

> Neglect is not providing enough care or supervision so that the child is injured or their development is damaged. It includes lack of food, shelter, affection, supervision, untreated medical problems and abandonment.
>
> Possible signs of neglect
> - signs of malnutrition, begging, stealing or hoarding food
> - poor hygiene: matted hair, dirty skin, or body odour
> - untreated medical problems
> - child or young person says that no one is home to look after them

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[145] Department for Child Protection and Family Support, *How do I recognize when a child is at risk of abuse or neglect?*,
Government of Western Australia, viewed 27 October 2019, <https://www.dcp.wa.gov.au/ChildProtection/Documents/HowDoIRecogniseWhenAChildIsAtRiskOfAbuseOrNeglect.pdf>, p. 2.
[146] World Health Organization and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A guide to taking action and generating evidence*, WHO, Geneva, Switzerland, 2006, p. 10.

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- child or young person always seems tired
- frequently late or absent from school
- clothing not appropriate to the weather
- alcohol and/or drug abuse in the home
- frequent illness, minor infections or sores
- hunger.[147]

Records indicate that 49 of the 115 children and young people (43 per cent) allegedly experienced one or more of the above forms of neglect.

1.4.1.4   Emotional abuse

The World Health Organization defines 'emotional and psychological abuse' as:

> … isolated incidents as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. Acts in this category may have a high probability of damaging the child's physical or mental health, or its physical, mental, spiritual, moral or social development. Abuse of this type includes: the restriction of movement; patterns of belittling, blaming, threatening, frightening, discriminating against or ridiculing; and other non-physical forms of rejection or hostile treatment.[148]

In its publications the Department of Communities distinguishes between:

- **emotional abuse**, that is, 'being treated in ways that damages a child's ability to feel and express a range of emotions … [through] behaviours that occur over time, such as verbal abuse and teasing, rejection, physical or social isolation, threats and bullying';[149] and

- **psychological abuse**: which includes 'being treated in ways that damages a child's self-esteem, personal and moral development and intelligence … [through] behaviours that occur over time, for example, belittling, threatening, isolating and causing the child to feel worthless.'[150]

However, since 1 January 2016, section 28 of the *Children and Community Services Act 2004*, has defined 'emotional abuse' as including both:

- psychological abuse; and

- exposing a child to an act of family violence as defined in the *Restraining Orders Act 1997*.

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[147] Department for Child Protection and Family Support, *How do I recognize when a child is at risk of abuse or neglect?*,
Government of Western Australia, viewed 27 October 2019, <https://www.dcp.wa.gov.au/ChildProtection/Documents/HowDoIRecogniseWhenAChildIsAtRiskOfAbuseOrNeglect.pdf>, p. 4.

[148] World Health Organization and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A guide to taking action and generating evidence*, WHO, Geneva, Switzerland, 2006, p. 10.

[149] G Department for Child Protection and Family Support, *How do I recognize when a child is at risk of abuse or neglect?*,
Government of Western Australia, viewed 27 October 2019, <https://www.dcp.wa.gov.au/ChildProtection/Documents/HowDoIRecogniseWhenAChildIsAtRiskOfAbuseOrNeglect.pdf>, p. 3.

[150] Department for Child Protection and Family Support, *How do I recognize when a child is at risk of abuse or neglect?*,
Government of Western Australia, viewed 27 October 2019, <https://www.dcp.wa.gov.au/ChildProtection/Documents/HowDoIRecogniseWhenAChildIsAtRiskOfAbuseOrNeglect.pdf>, p. 3.

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Records indicate that 27 of the 115 children and young people (23 per cent) allegedly experienced emotional or psychological abuse. This number excludes exposure to family and domestic violence, which is discussed separately in the following section.

1.4.1.5   Exposure to family and domestic violence

'Family violence', (also referred to as 'family and domestic violence' or 'domestic violence') is defined in section 5A(1) of the *Restraining Orders Act 1997* as:

- violence, or a threat of violence, by a person towards a family member of the person; or

- any other behaviour by the person that coerces or controls the family member or causes the member to be fearful.

Family violence may include, but are not limited to, the following examples listed in section 5A(2) of the *Restraining Orders Act 1997*:

(a) an assault against the family member;

(b) a sexual assault or other sexually abusive behaviour against the family member;

(c) stalking or cyber-stalking the family member;

(d) repeated derogatory remarks against the family member;

(e) damaging or destroying property of the family member;

(f) causing death or injury to an animal that is the property of the family member;

(g) unreasonably denying the family member the financial autonomy that the member would otherwise have had;

(h) unreasonably withholding financial support needed to meet the reasonable living expenses of the family member, or a child of the member, at a time when the member is entirely or predominantly dependent on the person for financial support;

(i) preventing the family member from making or keeping connections with the member's family, friends or culture;

(j) kidnapping, or depriving the liberty of, the family member, or any other person with whom the member has a family relationship;

(k) distributing or publishing, or threatening to distribute or publish, intimate personal images of the family member;

(l) causing any family member who is a child to be exposed to behaviour referred to in this section.

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The research literature relevantly identifies that children and young people exposed to family and domestic violence are:

> … 'silent, forgotten, unintended, invisible and/or secondary victims'. Forcing a child or young person to live in an environment where a primary caregiver experiences sustained violence is in and of itself emotional and psychological abuse. Children and young people who are forced to live with violence are at increased risk of experiencing physical and sexual abuse. These children and young people tend to experience significant disruptions in their psychosocial wellbeing, often exhibiting a similar pattern of symptoms to other abused or neglected children.

> Family violence commonly occurs with inter-related problems such as drug and alcohol misuse and mental illness. These inter-related problems exacerbate and increase the risks to children in these families.[151]

Records indicate that 53 of the 115 children and young people (46 per cent) allegedly experienced family and domestic violence.

1.4.2 Adverse family experiences

The research literature identifies that adverse family experiences (also known as 'adverse childhood experiences' or 'ACEs') increase the risk of attempted suicide among adolescents.[152] 'Adverse childhood experiences' are defined in the research literature as:

> … encompass[ing] any acts of commission or omission by a parent or other caregiver that result in harm, potential for harm or threat of harm to a child in the first 18 years of life, even if harm is not the intended result.[153]

The research literature also recognises that, although there is an established association between adverse family experiences and poor mental health[154] 'there is a limited understanding of how these complex parental factors affect parents' children and families'[155] and 'there should be no shame in having experienced adversity.'[156]

The adverse family experiences we consider in this report include living with family members who engage in substance use; are mentally ill; or who have been imprisoned.

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[151] Australian Government Australian Institute of Family Studies, *What is child abuse and neglect?*, CFCA, 2018, viewed 26 September 2018, <https://aifs.gov.au/cfca/publications/what-child-abuse-and-neglect>.

[152] Dube et al, '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,
pp. 3089-3096; Beautrais A, 'Risk factors for suicide and attempted suicide among young people', *Australia and New Zealand Journal of Psychiatry*, vol. 34, no. 3, 2000, pp. 420-436.

[153] Von Cheong E et al, 'Adverse childhood experiences (ACEs) and later-life depression: perceived social support as a potential protective factor', *BMJ Open*, vol. 7, no. 9, 2017, e:013228.

[154] Von Cheong E et al, 'Adverse childhood experiences (ACEs) and later-life depression: perceived social support as a potential protective factor', *BMJ Open*, vol. 7, no. 9, 2017, e:013228.

[155] Shaw AN et al, 'Parental Adverse Childhood Experiences and Resilience on Coping After Discharge', *Pediatrics*, vol. 141(4), April 2018, e:20172127.

[156] NHS Highland, Director of Public Health Annual Report 2018- Adverse Childhood Experiences, Resilience and Trauma Informed Care: A Public Health Approach to Understanding and Responding to Adversity, Argyll Bute Council, The Highland Council and NHS Highland, 2018, p. 7.

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Among the 115 children and young people, the recorded frequency of adverse family experiences was:

- 35 (30 per cent) were recorded as having a parent who had been diagnosed with a mental illness;

- 36 (31 per cent) were recorded as having a parent with alleged problematic alcohol or other drug use;

- 18 (16 per cent) were recorded as having a parent who had been imprisoned; and

- 16 (14 per cent) were recorded as having a family member, friend, or other person known to them who died by suicide.

1.4.3 Suicidal behaviour and ideation

1.4.3.1 Suicidal ideation

As discussed in Chapter 1.1.8.1 of this volume, suicidal ideation refers to recurrent thoughts of death, with or without a specific plan for committing suicide.

Sixty-five of the 115 children and young people (57 per cent) were recorded as having thoughts about 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.[157]

1.4.3.2 Communicated suicidal intent

Forty-one of the 115 children and young people (36 per cent) were recorded as having communicated their intention to die by suicide to a friend, family member or health professional.

1.4.3.3 Previous suicide attempts

Thirty-eight of the 115 children and young people (33 per cent) were recorded as having previously attempted suicide.

1.4.4 Mental-ill health

1.4.4.1 Mental health conditions

'Mental illness' is generally defined as a clinical diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities.[158] Also known as mental-ill health, mental health conditions, or mental health disorders, they 'comprise a broad range of problems but are generally characterised by some combination of

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[157] Scanlan F and Purcell R, 'Mythbuster, Suicidal ideation, MYTH: Asking young people about suicidal thoughts or behaviours will only put ideas into their heads', headspace, National Youth Mental Health Foundation Australia, 2009, viewed 26 October 2019, <https://headspace.org.au/assets/Uploads/Resource-library/Health-professionals/suicidal-ideation-mythbusterv2.pdf>, p. 1.
[158] Council of Australian Governments, *National Mental Health Policy 2008,* Commonwealth of Australia, Canberra, 2009,
viewed 26 October 2019, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/B4A903FB48158BAECA 257BF0001D3AEA/$File/finpol08.pdf>, p. 30.

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abnormal thoughts, emotions, behaviour and relationships with others', most of which can be successfully treated.[159]

Approximately 14 per cent of Australian children aged between 4 and 11 years were estimated to have experienced a mental health condition during 2013-14.[160] Mental health was also found to be the most important issue of concern for Australian young people in Mission Australia's *2017 Youth Survey*.[161]

Although many studies have considered the link between mental ill-health and suicide, estimates of the extent to which mental ill-health contributes to suicide rate vary, and are as high as 90 per cent in some studies.[162] However, 'the majority of people who have depression do not die by suicide'[163] with Coroners generally only reporting 'a history of mental disorder in less than 50 [per cent] of cases.'[164]

Thirty-eight of the 115 children and young people were recorded as having one or more diagnosed of mental health conditions (33 per cent), including:

- depressive disorders;

- anxiety disorders;

- behavioural, conduct and emotional disorders, including attention deficit disorder and disorders due to drug use;

- attachment disorders;

- post-traumatic stress disorder;

- obsessive compulsive disorder; and

- personality and eating disorders, including anorexia nervosa and bulimia nervosa.

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[159] Australian Institute of Health and Wellbeing, 'Children with mental illness', *Australia's children*, AIHW 2020, accessed 5 April 2020, <https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/children-with-mental-illness>.
[160] Lawrence D et al, The mental health of children and adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health , Canberra, 2015.
[161] Mission Australia, *Youth Survey Report 2017*, viewed 12 September 2018, <https://www.missionaustralia.com.au/documents/research/young-people-research/746-youth-survey-2017-report>.
[162] O'Connor RC and Nock MK, 'The psychology of suicidal behaviour', *The Lancet Psychiatry*, vol. 1, no. 1, 2014, pp. 73-85.; Mann JJ, 'The serotonergic system in mood disorders and suicidal behaviour', *Philosophical Transactions of the Royal Society of London B: Biological Sciences*, February 2013, vol. 368, no. 1615, doi: 10.1098/rstb.2012.0537.
[163] U.S. Department of Health and Human Services, 'Does depression increase the risk for suicide?', *Mental Health & Substance Abuse*, viewed 28 February 2019, <https://www.hhs.gov/answers/mental-health-and-substance-abuse/does-depression-increase-risk-of-suicide/index.html>.
[164] Pridmore S, 'Mental disorder and suicide: A faulty connection', *Australian and New Zealand Journal of Psychiatry*, 2015, vol. 49, no. 1, pp. 18-20.

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1.4.4.2   Self-harming behaviour

Self-harming behaviour is defined as someone deliberately harming themselves without suicidal intent.[165]

Self-harm is identified in the research literature as a significant risk factor for suicide in children and young people (as discussed in Chapters 1.1.9 and 4 of this volume). However, accurate data about the rate of self-harm by children and young people is not readily available, due to:

- variability in measuring tools;

- a lack of reliable data collection and monitoring systems;

- limited understanding of self-harm by young people and transient suicidal intent;

- changes in the recognised mechanisms of self-harming behaviour over time and for individuals (especially children and young people seeking to hide these behaviours); and

- children and young people not seeking help.[166]

The Office's analysis of the 115 children and young people identified that 40 children and young people (35 per cent) were recorded as having self-harmed at some point in their lives. Accordingly, in an effort to better understand the relationship between self-harm and suicide in children and young people in Western Australia, the Office obtained data from the Department of Health relating to hospital admissions for non-fatal intentional self-harm as discussed in Chapter 4 of this volume.

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[165] U.S. Department of Health and Human Services, 'Does depression increase the risk for suicide?', *Mental Health & Substance Abuse*, viewed 28 February 2019, <https://www.hhs.gov/answers/mental-health-and-substance-abuse/does-depression-increase-risk-of-suicide/index.html>.
[165] Pridmore S, 'Mental disorder and suicide: A faulty connection', *Australian and New Zealand Journal of Psychiatry*, 2015, vol. 49, no. 1, pp. 18-20.
[165] Lifeline Australia, *Self-harm*, viewed 26 September 2013, <http://www.lifeline.org.au/Get-Help/Facts---Information/Self-harm/Self-harm>.
[166] Hetrick S, *Suicide and Self-Harm in Adolescents* (Presentation to the NZ Early Intervention in Psychosis Training Forum), Christchurch, November 2017, viewed 22 September 2018, <https://www.tepou.co.nz/uploads/files/resource-assets/Sarah%20Hetrick%20-%20Suicide%20and%20self-harm%20in%20adolescents.pdf>.

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2. Strategic frameworks for preventing and reducing suicide by children and young people

2.1 Introduction

Suicide prevention strategies provide a systematic way for governments to respond to suicide through a range of coordinated prevention activities.

The World Health Organization identifies the common features and key elements of suicide prevention strategies in its report *Preventing Suicide: A global imperative*, as follows:

> Typical [suicide prevention] … strategies comprise a range of prevention strategies such as surveillance, means restriction, media guidelines, stigma reduction and raising of public awareness as well as training for health workers, educators, police and other gatekeepers. They also usually include crisis intervention services and postvention.
>
> Key elements in developing a … suicide prevention strategy are to make prevention a multisectoral priority that involves not only the health sector but also education, employment social welfare, the judiciary and others. The strategy should be tailored to each country's cultural and social context, establishing best practices and evidence-based interventions in a comprehensive approach. Resources should be allocated for achieving both short-to-medium and long-term objectives, there should be effective planning, and the strategy should be regularly evaluated, with evaluation findings feeding into future planning.[167]

2.2 The 2014 Investigation

In the 2014 Investigation, the Office identified that the Western Australian Suicide Prevention Strategy 2009 – 2013: Everybody's Business (**the former State Strategy**) was informed by the Mrazek and Haggerty *Spectrum of Interventions for Mental Health Problems and Mental Disorders* (**the Mrazek and Haggerty model**).[168]

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 set out in the former State Strategy, and found that:

- the patterns in the factors associated with suicide experienced by each of the four groups of young people may be aligned with different, albeit overlapping domains of suicide prevention activities;

- different suicide prevention activities may be relevant to each of the four groups of young people; and

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[167] World Health Organization, *Preventing suicide: a global imperative*, WHO, Luxembourg, 2014, p. 8.
[168] Mrazek P and Haggerty R (eds), Reducing risks for mental disorders: frontiers for preventative intervention research, National Academies Press, Washington, 1994.

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- 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.

2.3   Suicide prevention models

2.3.1   The Mrazek and Haggerty model

The Mrazek and Haggerty model divides interventions for mental health issues into three categories – Prevention, Treatment and Continuing Care – and further into eight domains within these categories. Similarly, the former State Strategy identified that it was based upon the 'Prevention' category of the Mrazek and Haggerty model, namely activities that 'can be targeted universally at the generally population … focus on selective at-risk groups or … be directed to those at risk as required.'

Figure 8: The Mrazek and Haggerty spectrum of interventions for mental health problems
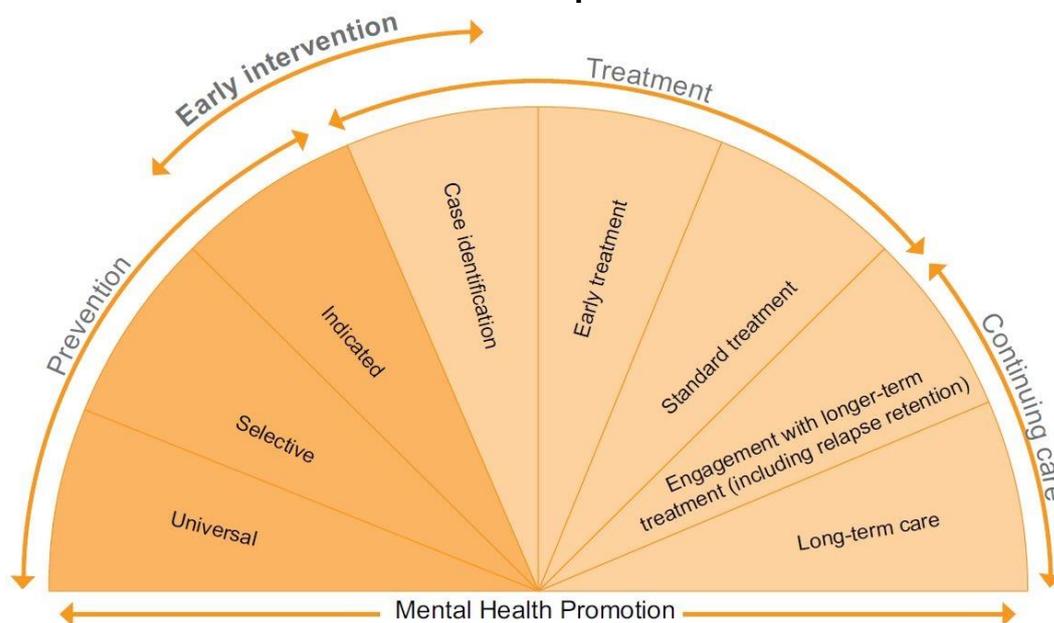
Source: Western Australian Suicide Prevention Strategy 2009 – 2013

The Mrazek and Haggerty model also identifies eight overlapping domains of care and support as shown in Figure 9. *Everymind* (formerly known as the Hunter Institute of Mental Health), has noted that the Mrazek and Haggerty model has facilitated a wide range of population interventions, but does not fully incorporate the spectrum of prevention activities:

> A focus on a broad spectrum of interventions allows for activities targeted at populations and individuals. It can help people to conceptualise different stages in the development of mental ill-health: from someone with no difficulties, through to non-specific problems or signs, through to a diagnosable mental illness. …
>
> The spectrum concept has been useful for policy makers and service providers in considering actions or interventions that might be most effective for people in different circumstances. It has been widely used in mental health settings and policies in Australia, but is not used or understood by sectors outside of health … [and has] not clearly articulated the full range of prevention

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activities (other than primary prevention), nor has it emphasised the importance of recovery. This has made these models less flexible in representing the entire array of initiatives available in prevention and promotion.[169]

Figure 9: Domains of suicide prevention activities

Domain	Activities associated with this domain
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.
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.
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 Framework[170] and Ombudsman Western Australia

The difficulties of implementing a model that has overlapping categories of intervention and domains of care in the Australian context, has been observed in the Fifth National Mental Health and Suicide Prevention Plan, which states that:

> The current approach to suicide prevention has been criticised as being fragmented, with unclear roles and responsibilities across governments. This has led to duplication and gaps in services for consumers. Where there are competing or overlapping services, there is a lack of clarity about which services are most effective or efficient.[171]

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[169] Everymind, Prevention First Framework: A Prevention & Promotion Framework for Mental Health, Version 2, Newcastle, Australia, 2017, p. 19.
[170] Department of Health and Aging, Living Is For Everyone (LIFE) Framework, Australian Government, Canberra, 2008.
[171] Council of Australian Governments Health Council, *The Fifth National Mental Health and Suicide Prevention Plan*, COAG Health Council, August 2017, p. 24.

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2.3.2 The systems-based approach to suicide prevention

Recent developments in the research literature overseas suggest that a multi-level, multifactorial, systems-based approach to suicide prevention can comprehensively reduce suicide risk, and has been endorsed by Australian researchers and policy makers, including the Chief Psychiatrist,[172] the Black Dog Institute[173] and Council of Australian Governments Health Council (**COAG**) in the Fifth National Mental Health and Suicide Prevention Plan:[174]

> The evidence for this position comes from the accumulation of studies of components of an approach …
>
> First, the US Airforce programme appears to be highly effective within a closed community. The programme consists of 11 components, and there is top-down accountability at every level of their implementation within the forces. All interventions have strict protocols.
>
> Second, the European Alliance Against Depression also took a multi-dimensional approach to suicide prevention. Evidence is now emerging that this approach reduces suicide.
>
> Third, a recent UK study examined the effect of nine components of health services and suicide outcomes. A does-response relationship was found: those health trusts which implemented none of the systems-based interventions had no reduction in suicides, while those which implemented more, did have reductions. Three programmes were particularly associated with reductions: - dual diagnosis policies, 24 hour crisis response services (which showed the greatest reduction) and multidisciplinary review after a suicide death.[175]

The key components of the systems-based approach are:

> … evidence-based interventions from population level to the individual, implemented simultaneously within a localised region. Multiple strategies implemented at the same time are likely to generate bigger effects than just the sum of individual parts due to synergistic effects.
>
> Integral to the success of this program is collaboration between local healthcare, community services, and those with lived experience. This encourages local ownership of activities and builds capacity for community

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[172] Chief Psychiatrist of Western Australia, 'An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring', 31 August 2017, viewed 9 May 2019, <https://www.chiefpsychiatrist.wa.gov.au/an-evidence-based-systems-approach-to-suicide-prevention-guidance-on-planning-commissioning-and-monitoring/>.

[173] Black Dog Institute, *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring,* Australian Government, National Health and Medical Research Council, Black Dog Institute, 2016, viewed 9 May 2019, <https://www.blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0>.

[174] Council of Australian Governments Health Council, *The Fifth National Mental Health and Suicide Prevention Plan*, COAG Health Council, August 2017, p. 24.

[175] Christensen H et al, *Literature Review for the Development of the Report Card: What works in suicide prevention*, National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention Black Dog Institute, Randwick, New South Wales, Australia, 2013, viewed 10 September 2018, <http://www.mentalhealthcommission.gov.au/media/100033/What%20works%20in%20suicide%20prevention.pdf>, p. 18.

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members to have an active role in the planning, development, implementation, and maintenance of these activities.

To be successful, services must provide inclusive care for all people in the community, taking into account their gender, sexuality, ethnicity, Indigenous status, history of trauma, and other factors that impact on how a person will seek assistance.[176]

In the Australian context, the systems-based approach is said to involve nine evidence-based suicide prevention strategies, namely:

- aftercare and crisis care following a suicide attempt;

- psychosocial and pharmacotherapy treatments;

- GP capacity building and support;

- frontline staff training;

- gatekeeper training;

- school programs;

- community mental health literacy campaigns;

- media reporting guidelines; and

- means restriction data collection, analysis and evidence-based practice.[177]

The systems-based approach is used by the Australian Government's Primary Health Network led National Suicide Prevention Trial, which includes three Western Australian trial sites:

- Perth South (targeted at the youth population);

- Mid-West WA (targeted at men aged 25 to 54 years); and

- Kimberley (targeted at Aboriginal peoples).[178]

2.3.3   Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (**ATSISPEP**) developed a:

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[176] Black Dog Institute, *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring,* Australian Government, National Health and Medical Research Council, Black Dog Institute, 2016, viewed 9 May 2019, <https://www.blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0>, p. 9.

[177] Black Dog Institute, *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring,* Australian Government, National Health and Medical Research Council, Black Dog Institute, 2016, p. 2, viewed 9 May 2019, <https://www.blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0>.

[178] Life in Mind, *Programs & resources, Regional approaches to suicide prevention – National Suicide Prevention Trial*, 2018, viewed 26 September 2018, <https://www.lifeinmindaustralia.com.au/programs-resources/regional-approaches/phn>.

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… set of success factors … and provided a foundation for a major project deliverable: a meta evaluation of evaluated, community-led, Indigenous suicide prevention programs. …

Consistent with the LiFE Framework, the success factors are organised into three levels of activity or intervention (universal, selected and indicated) and then further categorised to indicate responses for particular risk groups. …

A common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and 'lived experience' elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers. In addition, the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time.[179]

The success factors identified by ATSISPEP are identified in Figure 10.

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[179] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, pp. 1-2.

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Figure 10: ATSISPEP Success Factors

UNIVERSAL/ INDIGENOUS COMMUNITY – WIDE	Primordial prevention	• Addressing community challenges, poverty, social determinants of health • Cultural elements – building identity, SEWB, healing • Alcohol/drug use reduction
	Primary prevention	• Gatekeeper training – Indigenous-specific • Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy • Reducing access to lethal means of suicide • Training of frontline staff/GPs in detecting depression and suicide risk • E-health services/internet/crisis call lines and chat services • Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	School age	• School-based peer support and mental health literacy programs • Culture being taught in schools
	Young people	• Peer-to-peer mentoring, and education and leadership on suicide prevention • Programs to engage/divert including sport • Connecting to culture/country/Elders • Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	Clinical elements	• Access to counsellors/mental health support • 24/7 availability • Awareness of critical risk periods and responsiveness at those times • Crisis response teams after a suicide/postvention • Continuing care/assertive outreach post ED after a suicide attempt • Clear referral pathways • Time protocols • High quality and culturally appropriate treatments • Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	Community leadership/ cultural framework	• Community empowerment, development, ownership – community-specific responses • Involvement of Elders • Cultural framework
	Provider	• Partnerships with community organisations and ACCHS [Aboriginal Community Controlled Health Services] • Employment of community members/peer workforce • Indicators for evaluation • Cross-agency collaboration • Data collections • Dissemination of learnings

Source: ATSISPEP[180]

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[180] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 3.

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2.4   Suicide prevention strategies

2.4.1   The National Suicide Prevention Strategy

The National Strategy, as outlined in the 2014 Investigation, remains 'the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention.'[181] The National Strategy widened the focus of national suicide prevention efforts to address suicide prevention across all life stages, replacing the *National Youth Suicide Prevention Strategy 1995-1999*, which aimed to:

- prevent premature death from suicide among young people;[182]

- reduce rates of injury and self-harm;[183]

- reduce the incidence and prevalence of suicidal ideation and behaviour;[184] and

- enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.[185]

A key component of the National Strategy is the Living Is For Everyone (**LIFE**) Framework which '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.'[186]

The LIFE Framework includes six Action Areas:

- Action Area 1 – Improving the evidence base and understanding of suicide prevention;[187]

- Action Area 2 – Building individual resilience and the capacity for self-help;[188]

- Action Area 3 – Improving community strength, resilience and capacity in suicide prevention;[189]

- Action Area 4 – Taking a coordinated approach to suicide prevention;[190]

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[181] Department of Health, *National suicide prevention strategy*, Australian Government, Canberra, May 2012.
[182] Mitchell P, Valuing young lives: Evaluation of the National Youth Suicide Prevention Strategy, Australian Institute of Family Studies, Melbourne, 2000, p. 1.
[183] Mitchell P, Valuing young lives: Evaluation of the National Youth Suicide Prevention Strategy, Australian Institute of Family Studies, Melbourne, 2000, p. 1.
[184] Mitchell P, Valuing young lives: Evaluation of the National Youth Suicide Prevention Strategy, Australian Institute of Family Studies, Melbourne, 2000, p. 1.
[185] Mitchell P, Valuing young lives: Evaluation of the National Youth Suicide Prevention Strategy, Australian Institute of Family Studies, Melbourne, 2000, p. 1.
[186] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.
[187] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.
[188] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.
[189] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.
[190] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.

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- Action Area 5 – Providing targeted suicide prevention activities;[191] and

- Action Area 6 – Implementing standards and quality in suicide prevention.[192]

The LIFE Framework also includes the following youth suicide prevention activities:

- research the influence and impact on suicidal behaviours of new technologies;[193]

- develop and promote programs to enhance help-seeking among high risk groups including young people;[194] and

- expand and resource the capacity of schools to identify and provide support to those at risk.[195]

2.4.2 The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The National *Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (**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.'[196]

The ATSI Strategy identifies that communities that have strong cultural continuity have significantly lower rates of suicide among their young people, making cultural continuity a critical factor for Aboriginal and Torres Strait Islander suicide prevention:

> Australia's first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* was released in May 2013. It was underpinned by research that identified 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. By extension, they also conceive of themselves as having a future as bearers of a continuing stream of culture.[197]

The ATSI Strategy also identifies the need for culturally competent services that provide culturally safe management and treatment based on Aboriginal and Torres Strait Islander peoples' understanding of culture, family and connection to the land. Culturally competent

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[191] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.
[192] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 20.
[193] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 27.
[194] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 28.
[195] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework,* Australian Government, Canberra, 2008, p. 30.
[196] Department of Health and Aging, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Australian Government, Canberra, 2013, pp. 26-45.
[197] National Mental Health Commission, A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention, NMHC, Australian Government, Sydney, 2013, p. 89.

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suicide prevention services are those that are developed in partnership with the local community and Aboriginal and Torres Strait Islander Community Controlled Health Services, and aim to:

- 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;

- 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.[198]

2.4.3   The Fifth National Mental Health and Suicide Plan

On 4 August 2017, the COAG endorsed the Fifth National Mental Health and Suicide Prevention Plan in an effort to 'establish a national approach for collaborative government effort from 2017 to 2022' across the following eight priority areas:

- Achieving integrated regional planning and service delivery.

- Effective suicide prevention.

- Coordinated treatment and supports for people with severe and complex mental illness.

- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

- Improving the physical health of people living with mental illness and reducing early mortality.

- Reducing stigma and discrimination.

- Making safety and quality central to mental health service delivery.

- Ensuring that the enablers of effective system performance and system improvement are in place.[199]

There has been some criticism of the National Plan for 'a lack of attention on early intervention, prevention and young people'[200] and failing to 'explain the process by which

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[198] National Mental Health Commission, *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*, NMHC, Australian Government, Sydney, 2013, p. 89-90.
[199]Department of Health, Australian Government, *The Fifth National Mental Health and Suicide Prevention Plan*, 17 October 2017, p. 4.
[200] Orygen, The National Centre of Excellence in Youth Mental Health, *Response to the Draft Fifth National Mental Health Plan*, viewed 9 May 2019, <https://www.orygen.org.au/Policy-Advocacy/Government-policy-service-delivery-and-workforce/Government-policy/Response-to-the-draft-Fifth-National-Mental-Health/Orygen-Fifth-National-Mental-Health-Plan-Dec-2016?ext=.>, p. 3.

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national approaches translate to jurisdictional, then regional, then local and individual action' or include relevant funding.[201]

2.4.4 The Youth Suicide Prevention Plan for Tasmania 2016-2020

Tasmania is currently the only Australian state with a specific youth suicide prevention plan that was 'developed in response to community concerns about the health and wellbeing of [Tasmania's] young people'[202] aged 12-25 years. The Youth Suicide Prevention Plan for Tasmania was written as a 'companion document' to the *Tasmanian Suicide Prevention Strategy 2016-2020* and:

> … takes an evidence-based approach to … reduce suicide, suicidal behaviour and the impact on young people in Tasmania.
>
> The Plan identifies five priority action areas:
> 1. Start early.
> 2. Empower young people, families and communities.
> 3. Build the capacity of schools.
> 4. Develop the capacity of the service system.
> 5. Respond effectively to the suicide of a young person.[203]

This plan was developed following extensive consultation with the Youth Network of Tasmania, which relevantly identified that children and young people were of the view that:

- families have an important role in suicide prevention
- technology is important for accessing information and connection young people to services
- training teachers and support staff in school is important
- services need to be responsive to the needs of young people
- they could help if they knew what to say and how to encourage their peers to access support.[204]

The Parliament of New South Wales Joint Committee on Children and Young People recently considered the Tasmanian youth suicide prevention plan in its inquiry into *Prevention of Youth Suicide in New South Wales* and:

- noted that 'children and young people have specific needs and … developing a youth specific suicide prevention plan will assist in focusing attention on children and young people and guide decision making';[205] and

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[201] Rosenberg S, 'Shangri-La and the integration of mental health care in Australia', *Public Health Research and Practice*, vol. 27, no. 3, July 2017, viewed 9 May 2019, <http://www.phrp.com.au/wp-content/uploads/2017/07/17-049-PHRPJUL17-Mentalhealth.pdf>.

[202] Department of Health and Human Services, Tasmanian Government, *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, March 2016, p. 6.

[203] Department of Health and Human Services, Tasmanian Government, *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, March 2016, p. 7.

[204] Department of Health and Human Services, Tasmanian Government, *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, March 2016, p. 7.

[205] Joint Committee on Children and Young People, *Prevention of Youth Suicide in New South Wales, Report 5/56*, Parliament of New South Wales, Sydney, October 2018, p. 10.

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- recommended that the New South Wales Government 'develop a youth specific suicide prevention plan developed in consultation with children and young people'.[206]

The New South Wales Government recently supported in principle the recommendation to 'develop a youth specific suicide prevention plan developed in consultation with children and young people.'[207]

2.4.5 Australian Government Youth Mental Health and Suicide Prevention Plan

On 8 July 2019, the Prime Minister of Australia announced that the Australian Government was committing:

> $503 million [to a new] Youth Mental Health and Suicide Prevention Plan … [including] a major expansion of the headspace network and a significant boost to Indigenous suicide prevention and early childhood and parenting support.[208]

Ms Christine Morgan, Chief Executive Officer of the National Health Commission has also been appointed as the National Suicide Prevention Adviser to the Prime Minister to undertake four key tasks:

- Report on the effectiveness of the design, coordination and delivery of suicide prevention activities in Australia, with a focus on people in crisis or increased risk, including young people and our first nations people;
- Develop options for a whole-of-government coordination and delivery of suicide prevention activities to address complex issues contributing to Australia's suicide rate, with a focus on community-led and person-centred solutions;
- Work across government and departments to embed suicide prevention policy and culture across all relevant policy areas to ensure pathways to support are cleared, and people who are at an increased risk of suicide are able to access support; and
- Draw upon all current relevant work government and the sector is undertaking to address suicide, including the Fifth National Mental Health and Suicide Prevention Plan and Implementation Strategy, and the findings of the Productivity Commission and Royal Commission into Victoria's Mental Health System inquiries.[209]

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[206] Joint Committee on Children and Young People, *Prevention of Youth Suicide in New South Wales, Report 5/56*, Parliament of New South Wales, Sydney, October 2018, p. 11.

[207] Joint Committee on Children and Young People, *Prevention of Youth Suicide in New South Wales, Report 5/56*, Parliament of New South Wales, Sydney, October 2018, p. 16.

[208] The Hon Scott Morrison MP, Prime Minister of Australia, *Media Release: Making suicide prevention: a national priority*, 8 July 2019, viewed, 28 October 2019, <https://www.pm.gov.au/media/making-suicide-prevention-national-priority>.

[209] National Mental Health Commission, *Commission CEO appointed the National Suicide Prevention Adviser to the Prime Minister*, 8 July 2019, viewed 28 October 2019, <https://www.mentalhealthcommission.gov.au/media-centre/news/commission-ceo-appointed-the-national-suicide-prevention-adviser-to-the-prime-minister.aspx>.

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2.5 The State Strategy - Suicide Prevention 2020: Together we can save lives

2.5.1 Background

In the 2014 Investigation, the Office considered the State level strategic framework for suicide prevention, the *Western Australian Suicide Prevention Strategy 2009-2013* (**the former State Strategy)***,* which:

- was based on the National Strategy;

- provided 'the foundational framework for the State government to coordinate and invest in suicide prevention strategies at all levels in the community';[210] and

- included 'a particular emphasis on young people, young men, Aboriginal people and people who live in rural and regional Western Australia.'[211]

2.5.2 Auditor General Review of the Western Australian Suicide Prevention Strategy 2009–2013

The Auditor General's 2014 Report on The Implementation and Initial Outcomes of the Suicide Prevention Strategy concluded that:

> … the Strategy succeeded in engaging communities in planning and participating in suicide prevention activities that they felt would work for them. This delivered benefits for individuals and communities.
>
> But the benefits could have been greater. Delays resulted from a poor procurement process, the initial planning was inadequate and governance arrangements were unclear and inefficient. These issues cost time, effort and money that could have been spent on prevention activities. Changes were made in 2012 and 2013, increasing the number of community action plans, but other parts of the Strategy were not completed.[212]

In particular, the Auditor General found that 'Action Area 4: Taking a coordinated approach to suicide prevention' of the 2009-2013 State Strategy was 'not being fully implemented' and that:

> The lack of an implementation plan covering the life of the Strategy reduced the Council's capacity to ensure progress across all action areas.
>
> For instance, 65 per cent of the funds went to CAPs, but there is no way to show if this was what the Council intended or if it achieved what the Strategy set out to do. We found no documented reason for the Council prioritising CAPs over other action areas, such as taking a coordinated approach to suicide prevention between communities, agencies and all levels of government. …

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[210] Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Government of Western Australia, Perth, 2009, p. 8.
[211] Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Government of Western Australia, Perth, 2009, p. 4.
[212] Auditor General, The Implementation and Initial Outcomes of the Suicide Prevention Strategy, Perth 2014, p. 4.

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A lack of focus on coordinating approaches to suicide prevention (Strategy Action Area 4) meant that opportunities to sustain and improve the effectiveness of suicide prevention measures has been missed. Aligning new and existing activities could have extended the life of the new activities and reduced the money, time and effort needed to set up new services.[213]

2.5.3 Current State Strategy: *Suicide Prevention 2020*

The current State Strategy, *Suicide Prevention 2020: Together we can save lives* (***Suicide Prevention 2020***) was released in 2015, and identifies young people who have experienced certain risk factors as a priority population, similar to the factors associated with suicide experienced by the 36 young people analysed in the 2014 Investigation, as follows:

> Children, young people and adults who have experienced mental illness, alcohol and other drug issues, trauma or exposure to suicide are at much higher risk of suicidal behaviour and death. An individual's physical, cultural and social circumstances can result in greater disadvantage and risk of suicide. *Suicide Prevention 2020* therefore outlines priority populations for suicide prevention actions across Western Australia.[214]

The (then) Minister for Mental Health stated in the Foreword to *Suicide Prevention 2020* that it 'aims to halve the number of suicides in ten years'[215]. As part of the 2019-20 State Budget, the State Government allocated an additional $8.1 million to extend *Suicide Prevention 2020* for a further 18 month period beyond 30 June 2019.[216] On 3 July 2019, the Mental Health Commission announced that it was:

> … developing a new suicide prevention strategy, the *Suicide Prevention Action Plan 2021-2025*.

> Building on the work of *Suicide Prevention 2020: Together we can save lives*, the *Suicide Prevention Action Plan 2025* will provide a guide on activities that can help Western Australian communities reduce the incidence of suicide.

> Conversations have begun to help inform the activities to be included in the *Suicide Prevention Action Plan 2025*, with community consultation currently underway in regional and metropolitan communities.

> The Commission will work to align the *Suicide Prevention Action Plan 2025* with existing national and state-based strategies.[217]

The priority populations outlined in *Suicide Prevention 2020* are:

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[213] Auditor General, The Implementation and Initial Outcomes of the Suicide Prevention Strategy, Perth 2014, pp. 17, 24.
[214] Mental Health Commission, Suicide Prevention 2020: Together we can save lives, Perth, 2015, p. 20.
[215] Mental Health Commission, Suicide Prevention 2020: Together we can save lives, Perth, 2015.
[216] Government of Western Australia, *WA State Budget 2019-20: Putting Patients First*, 2019, viewed 28 October 2019, <https://www.ourstatebudget.wa.gov.au/2019-20/fact-sheets/health.pdf>; Aboriginal Health Council of Western Australia, Moorditj Koort and Western Australian Association for Mental Health, *Media release: State Budget does not properly address Aboriginal suicide prevention*, 10 May 2019, viewed 28 October 2019, <https://waamh.org.au/assets/documents/media-releases/media-release-joint-statement-aboriginal-suicide-prevention-budget-may-2019_final.pdf>.
[217] Mental Health Commission, Help inform the Western Australian Suicide Prevention Action Plan 2021-2015, 3 July 2019.

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- people who have attempted suicide; [218]

- people who are bereaved by suicide;[219]

- Aboriginal people;[220]

- people from culturally and linguistically diverse backgrounds;[221]

- lesbian, gay, bisexual, transgender and intersex people;[222]

- people living in rural and remote areas; [223] and

- people in the justice system.[224]

Targeted resilience and protective factors for young people across the early years, school age and young adult years are also set out in *Suicide Prevention 2020*, as summarised in Figure 11:

Figure 11: Life stages and targeted protective factors

Life stage	Targeted protective factors
Early years	• Family physical, emotional and psychological wellbeing; • Caring and healthy relationships; • Effective parenting and coping skills; • Extended family and community support; • Positive early childhood development and healthy attachment; and • Access to child health nurses, quality childcare and local family centres.
School age	• Development of good self-esteem, communication and coping skills; • Supportive relationships with family, peers and the wider community; • Engagement in school, education and recreation activities; • Development of self-worth, personal safety and healthy boundaries; and • Significant adult who is a positive role model.
Young adults	• Ability to care for their own health and wellbeing and access support; • Capacity to create satisfying personal and social relationships; • Skills to cope with difficult emotions or problems; • Development of skills to live independently and reach personal goals; and • Successful transition from school to work or study.

Source: Suicide Prevention 2020

[218] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.
[219] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.
[220] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.
[221] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.
[222] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.
[223] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.
[224] Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.

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2.5.4 The Mental Health Commission developed a *Suicide Prevention 2020* Implementation Plan, Aboriginal Implementation Plan and Youth Engagement Strategy but has not released these documents publicly as recommended by the *Learnings from the message stick* report

Suicide Prevention 2020 identifies that:

> A *Suicide Prevention 2020* Implementation Plan for 2015-2020 will detail activities, resources and lead agencies required. The Implementation Plan will define actions, allocate responsibility, and identify outputs and outcomes. Progressive independent evaluation will be implemented to enable effective monitoring and reporting to ensure ongoing improvement.[225]

In its 2016 report, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas* (***Learnings from the message stick***), the Education and Health Standing Committee observed that:

> To guide actions under *Suicide Prevention 2020*, an Implementation Plan, Aboriginal Implementation Plan and Youth Engagement Strategy have been developed but are not publicly available. Without the benefit of seeing these additional plans and strategy, *Suicide Prevention 2020* appears to lack the comprehensiveness of approach to mental health and wellbeing of Aboriginal people and children and young people.

> The MHC indicated that it consulted with Aboriginal communities across the state during 2015 "to discuss the ways in which the views of Aboriginal communities and leaders can be aligned with *Suicide Prevention 2020*." As the Aboriginal Implementation Plan will not be made public, it is unclear the extent to which this plan incorporates the outcomes of the consultation process. Clearly unaware of the internal nature of these documents, submissions have recommended that the Western Australian Government urgently fast-track the Aboriginal Implementation Plan and the Youth Engagement Strategy, demonstrating the importance of this plan and strategy, and the interest in it being made publicly available.

> The Committee was also concerned about some of the phrasing in the MHC's written response to questions. The MHC indicated that it is the views of Aboriginal communities and leaders which are being 'aligned' with *Suicide Prevention 2020*, rather than the other way around. Perhaps just a poor turn of phrase, this approach appears to follow in the footsteps of many preceding government policies which have not improved the lives of Aboriginal people. Attempts to force a general population model to fit Aboriginal communities suggests a failure to listen to Aboriginal voices, despite the evidence in this report that meaningfully addressing the suicide crisis will require much greater Aboriginal involvement and empowerment.[226]

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[225] Mental Health Commission, Government of Western Australia, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, p. 30.
[226] Education and Health Standing Committee, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*, Legislative Assembly, Parliament of Western Australia, Perth, November 2016, p. 114.

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Recommendation 22 of the *Learnings from the message stick* report was:

> That the Mental Health Commission immediately make publicly available the *Suicide Prevention 2020: Together we can save lives* Implementation Plan, Aboriginal Implementation Plan and Youth Engagement Strategy.[227]

However, to date, the Mental Health Commission's *Suicide Prevention 2020* Implementation Plan, Aboriginal Implementation Plan and Youth Engagement Strategy have not been released publicly.

2.5.5 There are similarities between Commonwealth and State government suicide prevention strategies

A review of Australian suicide prevention strategies by the National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention (Black Dog Institute) undertaken for the National Mental Health Commission, found many similarities in the suicide prevention strategies at both the Commonwealth and State/Territory levels:

> Overall, the jurisdictional strategies are comprehensive and detailed. … Of the policies that were accessible, the majority addressed at least some of the [intervention strategies] within each broad area [of suicide prevention]. Most jurisdictional policies sought to engage multiple stakeholders and to coordinate between federal and jurisdictional levels, to build capacity within the health system and the wider community, to promote knowledge of effective interventions, and to develop implementation plans and evaluate the strategy. For many, this last area was brief and imprecise. …
>
> Missing from most of the Australian jurisdictional strategies was the aim to address the social determinants of suicide, e.g. unemployment, inequality, unemployment and violence. Although most policy documents and strategies acknowledged the roles that alcohol plays in contributing to suicide, none included a specific focus on addressing alcohol abuse (and/or dual diagnosis). Also missing from most was clear recognition or plan to develop multi-compartmental strategies.[228]

Despite these synergies between Australian suicide prevention strategies, and recognition of 'Australian articulation of national mental health policy [as] … world leading':[229]

> … the implementation of suicide prevention policies has been less comprehensive. Indeed, there has been frustration about the piecemeal and uncoordinated effects of State and Federal actions. At the same time,

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[227] Education and Health Standing Committee, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*, Legislative Assembly, Parliament of Western Australia, Perth, November 2016, p. 115.

[228] Christensen H et al, *Literature Review for the Development of the Report Card: What works in suicide prevention*; National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention Black Dog Institute, Randwick, 2013, viewed 10 September 2018, <http://www.mentalhealthcommission.gov.au/media/100033/What%20 works%20in%20suicide%20prevention.pdf>, pp. 23-24.

[229] National Mental Health Commission, Contributing Lives, Thriving Communities: National Review of Mental Health Programmes and Services: Volume 4 – Paper 2: Mental health need and Australia's response, NMHC, Sydney, 2014, viewed 10 September 2018, <http://www.mentalhealthcommission.gov.au/media/119956/Vol %204%20Paper%202%20-%20Review%20of%20Mental%20Health%20Programmes%20and%20Services.pdf>, p. 3.

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evidence from Europe and Japan has been mounting that the best suicide prevention approach is likely to be gained from a multi-level, multifactorial systems based approach.[230]

There is some suggestion that funding levels, models and accountability for suicide prevention activities remain a sizeable challenge in a federated service delivery environment:

> There have been 32 statutory inquiries into mental health between 2006 and 2012 alone, most summarising the situation as being in crisis. Funding remains low (6% of the health budget) in comparison to the burden of disease (13%), rate of access to care remain unacceptably low, particularly for some key groups and investment in alternatives to hospitalisation is meagre.[231]

The National Mental Health Commission has also recommended the shift to a systems-based approach to suicide prevention in its *National Review of Mental Health Programmes and Service Delivery*, and that the Australian Government, in collaboration with States, Territories and people with lived experience, their families and support people:

- build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties; and

- identify, develop and implement a national framework to support families and communities in the prevention of trauma from abuse and neglect during infancy and early childhood, and to support those impacted by childhood trauma.[232]

It is important to note that, regardless of the particulars of a suicide prevention strategy, or the theoretical model informing it:

> … the impact of them relied just as much on the extent that identifications of coverage of the at-risk population is feasible and implementable as it relies on the size of the [preventative] effect. For instance, a highly effective strategy may have little impact if it can only be delivered to a small number of people. A relatively ineffective strategy which has the potential for huge roll-out can have high impact.[233]

2.5.6 Children and young people at risk of suicide are at developmentally different stages to adults at risk of suicide, and face different risk factors and barriers to accessing services

In 2016, Orygen published a report on *Raising the Bar for Youth Suicide Prevention* in which it observed that:

[230] Christensen H, 'Suicide prevention in Australia: Where to from here', *InPsych,* vol. 38, no. 1, 2016, viewed 10 September 2018, <https://www.psychology.org.au/inpsych/2016/feb/Christensen>.

[231] Rosenberg S, 'Activity-based funding and mental health: a rejoinder', *Australasian Psychiatry*, vol. 26, no.3, June 2018, p. 325.

[232] National Mental Health Commission, Contributing Lives, Thriving Communities: National Review of Mental Health Programmes and Services: Summary, Australian Government, Sydney, 2014, p. 17.

[233] Christensen H, 'Suicide prevention in Australia: Where to from here', *InPsych,* vol. 38, no. 1, 2016, viewed 10 September 2018, <https://www.psychology.org.au/inpsych/2016/feb/Christensen>.

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Over the past 10 years, rather than making in-roads into reducing the number of young lives lost to suicide in Australia, there have instead been small but gradual increases in suicide rates. Twice as many young women aged 15-19 years died by suicide in 2015 than 2005 and rates have also increased among young people under the age of 14 years.

This has mirrored high rates of self harm among young people. …

In 1995 Australia was one of the first countries in the world to develop a suicide prevention strategy, focused initially on young people. Successive national and state/territory suicide prevention strategies have been released although available evaluations are unable to link these to reductions in suicide or suicide-related behaviours at a national or community level. Further, an analysis of current suicide prevention policies across the country has identified gaps in evidence-based and young person appropriate, accessible and acceptable programs and services. We cannot afford to continue to focus on policies, programs and activities for which limited evidence exists; the cost of these tragic and preventable deaths is too great.[234]

Orygen suggest that a youth specific strategic response to suicide prevention is required for a number of reasons, including that:

- young people are at increased susceptibility to the onset of mental health issues due to the age and stage of their development and the 'well-documented elevated risk of suicide among those … young people with serious and complex experiences of mental ill-health, for example affective disorders, personality disorders and psychosis';[235]

- high rates of self-harm in young people 'should act as an early indication for service providers and policy makers that many young people are distressed and crying out for help';[236] and

- data analysis 'has shown that a youth suicide is more likely to be part of a cluster than an adult suicide … [suggesting] that responding to suicide among young people requires a different approach than for other age groups.'[237]

Orygen identified some of the additional measures (beyond those in the *National Suicide Prevention Strategy*) needed to effectively prevent to suicide by children and young people through consultation with young people and stakeholders, as set out in Figure 12:

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[234] Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

[235] Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

[236] Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

[237] Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

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Figure 12: Orygen consultation summary: *An effective national youth*
suicide prevention policy response

The *National Suicide Prevention Strategy* requires:	A youth suicide prevention response would also require:
A national plan with clear objectives, priorities for activities to be delivered: a) nationally, b) at a state/territory level and c) regionally.	A separate youth suicide prevention implementation plan which describes activities and partnerships in settings where young people are engaged and likely to seek help e.g. education settings (primary, secondary, community and tertiary) and families. This is an age group who may not have had contact with the health system yet.
Communication and clarity of roles to ensure that suicide prevention activities (including the role for step-down care following discharge from services) are integrated.	Actions, roles and responsibilities are identified across all portfolios (in all levels of government) relevant to young people and the social determinants of suicide risk including: education, health, justice, social and community services.
An advisory mechanism with genuine capacity to direct suicide prevention action, such as Australian Suicide Prevention Advisory Council.	Young people represented on, or consulted by, this advisory mechanism with a commitment to genuine partnerships with young people in the process of developing and providing advice to government.
A strategic approach and adequate funding in order to conduct relevant research and build the evidence base in suicide prevention.	New and innovative youth suicide prevention activities are funded and researched.
Ready access to existing evidence through the development of a 'Better Practice Register'.	Ensure that the evidence base clearly identifies youth appropriate, acceptable and effective strategies and that this information is made available to commissioners and providers.
A robust and nationally consistent evaluation framework developed and resourced from the outset.	Evaluations that seek out young people's views to a) ensure youth-related outcomes are collected and b) determine the program's acceptability and appropriateness.
Improved national data collection and monitoring to understand the prevalence and impact of suicide-related behaviours.	Building on existing (and create new) national data collection instruments to ensure that the right questions are asked in the right way to collect information from young people.
A parallel national suicide prevention workforce development strategy.	Building competency in a workforce that a) young people are most likely to seek help from (including peers and family) and b) are in regular contact with young people and in a position to identify risk (including teachers, youth workers, sports administrators, music clubs).

Source: Orygen (2016)

The National Children's Commissioner has also identified unique barriers faced by children and young people seeking help for self-harm and suicidal behaviours, as compared with adults, including:

- Barriers experienced by children and young people included feelings of embarrassment and guilt, and fear of the response from parents and other sources of help.

- Barriers associated with parents and carers included limited awareness of available support services and worries about cost of services/treatments.

- Barriers as a result of system constraints included lack of appropriate and culturally sensitive support services and limited capacity of support

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services where there are waiting lists and motivation to seek support may have decreased by the time an appointment is available.[238]

2.5.7 The research literature identifies the importance of regular evaluation in working towards a comprehensive response to suicide prevention

The World Health Organization identifies the importance of defining outcomes and capturing systemic outcome-related data in the implementation of suicide prevention strategies, as follows:

Outcomes

The changes, results and benefits achieved for individuals, groups, agencies, communities and/or systems due to the activities and other outputs … should be categorized as short-term, intermediate or long-term and should be measurable, such as:
- numbers of suicides and suicide attempts;
- numbers trained or otherwise influenced by individual activities;
- hours of accessible services;
- numbers treated;
- measures reflecting a decrease in perceived stigma regarding help-seeking;
- improvement in provision of mental health service;
- mental health, well-being or connectedness;
- measures reflective cost-effectiveness; and
- reduced rates of hospitalizations due to suicide attempts, or deaths by suicide.

The importance of data

… the problem to be solved, reduced changed or prevented must first be understood. Surveillance refers to the systematic collection of outcome-specific data (most importantly on suicides and suicide attempts) "for use in the planning, implementation and evaluation of public health practice". … Measuring the success, or lack thereof, of efforts to reduce suicide, suicide attempts or the impact of suicide on society at large requires access to reliable and valid data. Quality improvement depends on having data that point to where the needs for improvement exist.[239]

The World Health Organization also recognises the importance of evaluation as an 'integral component of any … suicide prevention strategy' that adds value through:

Knowledge production: Evaluation provides stakeholder groups with important information on the strategy's progress and on its strengths and weaknesses. This information can be used to monitor the success of the strategy in achieving short-term, intermediate and long-term outcomes and is a basis for making modifications as needed and for guiding future planning and resource allocation.

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[238] Australian Human Rights Commission, *Intentional self-harm and suicidal behaviour in children*, AHRC, Sydney, June 2018, viewed 10 September 2018 <https://www.humanrights.gov.au/our-work/childrens-rights/projects/intentional-self-harm-and-suicidal-behaviour-children>.
[239] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 60.

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Planning and management: Evaluation offers ways to improve how the national strategy and its component activities are planned and managed. It enables the development of clear outcome-oriented plans and inclusive partnerships, as well as systems for data-gathering and feedback that encourage learning and ongoing improvement.

Accountability: Evaluation is a tool for demonstrating accountability to funders, legislators and the general public. It helps ensure that the most effective approaches are maintained and that resources are not wasted on ineffective programmes.

… If reduction in suicidal behaviours, mitigation of risk factors and strengthening of protective factors are not achieved by a … strategy, it is critical to know whether this was due to a lack of implementation.[240]

2.5.8 In some other Australian jurisdictions, evaluation frameworks have been incorporated into suicide prevention strategies

The *Victorian Suicide Prevention Framework 2016-25* includes a requirement for the government to 'report annually on progress, with suicide prevention as part of the annual report to parliament on mental health' with the 'measure for assessing progress' also set as 'the age-standardised rate of deaths from intentional self-harm as reported annually by the Australian Bureau of Statistics'.[241]

In 2017-18 the Department of Health and Human Services' *Victoria's Mental Health Services Annual Report 2017-18* relevantly noted that:

We have observed small reductions in both suicides and deaths due to intentional self-harm since releasing the Victorian suicide prevention framework 2016–25. During 2017 we lost 621 Victorians to suicide, down from 624 in 2016 and 654 in 2015. Victoria now has the lowest suicide rate of all Australian states and territories, with a rate of 9.6 deaths (per 100,000) compared with 9.9 (per 100,000) in 2016.

In contrast, Australia's national suicide rate has increased to 12.6 (per 100,000) in 2017, up from 11.7 (per 100,000) in 2016. Suicide remains the leading cause of death for Australians aged 15–44 years and the second leading cause of death among Australians aged 45–54. During 2017–18 Victoria began leading development of a national suicide prevention implementation strategy on behalf of all Australian governments.[242]

In the *Tasmanian Suicide Prevention Strategy (2016-2020): Working together to prevent suicide* and the accompanying *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, the evaluation framework for suicide prevention actions for children and young people are set out as part of these strategic documents, as set out in Figure 13.

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[240] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014,
p. 61.
[241] Department of Health and Human Services, *Victoria's 10 Year Mental Health Plan:*
Victorian Suicide Prevention Framework 2016-25, Victorian Government, Melbourne, 2016, p.28.
[242] Department of Health and Human Services, *Victoria's 10 Year Mental Health Plan:*
Victorian Suicide Prevention Framework 2016-25, Victorian Government, Melbourne, 2016, p. 5.

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Figure 13: Tasmanian Youth Suicide Prevention Plan Evaluation Framework

Actions				
Start early	Empower young people, families and communities	Build the capacity of schools	Develop the capacity of the service system	Respond effectively to the suicide of a young person

Short-term effects		
Access to interventions (existing and new) that build resilience and wellbeing of children and young people	Increased ability to recognise suicidal behaviour, talk about it and respond appropriately	Increased service integration, early access to services and improved care for young people and their families

Long-term effects		
Improved capacity for workforces and communities to support the mental health and wellbeing of young people	Improved capacity for the service system to respond to suicidal behaviours of young people	Improved responses to young people, families and communities following a suicide

Outcomes				
Reduced rates of youth suicide	Reduced rates of suicidal behaviour among young people	Young people are connected to families, and/or education and/or work	Reduced impact of suicidal behaviour	Better mental health and wellbeing for Tasmanian youth

Source: Youth Suicide Prevention Plan for Tasmania (2016-2020)[243]

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[243] Department of Health and Human Services, *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, Tasmanian Government, March 2016, p. 12.

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By way of contrast, over the same period, Western Australia's age standardised rate for deaths by suicide rate has increased from 14.4 deaths (per 100,000) in 2016 to 15.8 deaths (per 100,000) in 2017.[244]

Recommendation 1: That the Mental Health Commission develop a specific suicide prevention plan for children and young people, developed with children and young people (and their advocates, including the Commissioner for Children and Young People) including those with experiences of abuse and neglect and children and young people with diverse gender identity and sexual identity.

This suicide prevention plan for children and young people should:

- describe specific prevention activities to engage children and young people, activities to promote help-seeking by children and young people, the outcomes these activities are intended to achieve and the methodology that will be used to evaluate the efficacy of those activities, and the plan as a whole;
- include provision for annual reporting on the rate of suicide by children and young people, hospital admissions for self-harm and suicidal ideation by children and young people; and emergency department attendances for self-harm by children and young people;
- include measures to address inequity in child and adolescent mental health service provision and suicide prevention in regional and remote areas with high rates of suicide and self-harm; and
- include processes for seeking out the views of children and young people in developing, commissioning and evaluating suicide prevention activities and other mental health, drug and alcohol activities to ensure that data is collected in relation to: (a) outcomes for children and young people receiving services under the plan and (b) the acceptability and appropriateness of activities and programs are assessed from the perspective of children and young people accessing the service.

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[244] Australian Bureau of Statistics, 'Table 11.7 Intentional self-harm by State and territory of usual residence and Sex, Age-standardised death rates, 2009-2018', Causes of Death, Australia, 2017, cat. no. 3303.0, ABS, Canberra, September 2018; Australian Bureau of Statistics, 'Table 11.2 - Intentional self-harm, Age-specific death rates, 5 year age groups by sex, 2008-2017', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

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3. Suicide by children and young people in Western Australia

> *When someone dies by suicide, their family, loved ones, and communities are often forever changed. ... Each suicide leaves behind as many as 130 people who report they directly knew the person.[245]*
>
> *Childhood and adolescence are key suicide 'prevention window' periods. Approximately one half of emotional and behavioural disorders that are well-defined risk factors for suicide have onset of symptoms by age 14 years. Many effective programs for children and adolescents prevent or reduce the severity of these mental, emotional, and behavioural problems … In addition to being a critical period for preventing disorders, childhood and early adolescence are important periods for preventing the onset of suicidal behaviours. Adolescence is the age period of the highest rates of attempted suicide, and each attempt increases risk for future attempts and death due to suicide.[246]*

3.1 Introduction

3.1.1 National suicide prevention strategies and *Suicide Prevention 2020* emphasise the importance of timely data collection to improve suicide prevention efforts

Improving data collection is a key pillar of the National Strategies for preventing suicide, namely the LIFE Framework,[247] the Fifth National Mental Health and Suicide Prevention Plan,[248] the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy[249] and ATSISPEP.[250]

ATSIPEP also developed a discussion paper on *Real Time Suicide Data* which observed the importance of timely and accurate data collection in improving responses to suicide by Aboriginal and Torres Strait Islander people, as follows:

> More accurate data collection is a positive outcome of the significant and ongoing changes which have been made in recent times. However, data collection particularly real time data remains an important issue. There needs

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[245] Cerel J and Sanford R, 'The impact of suicide: World Suicide Prevention Day and why suicide awareness matters', *OUP blog*, Oxford University Press, 2016, viewed 26 September 2018,
<https://blog.oup.com/2016/09/impact-awareness-suicide-prevention-day/>.
[246] Wyman P, 'Developmental Approach to Prevent Adolescent Suicides: Research Pathways to Effective Upstream Preventative Interventions,' *American Journal of Preventive Medicine*, vol.47 no. 302 (Supplement 2), pp. S251-S256,
doi: 10.1016/j.amepre.2014.05.039.
[247] Department of Health and Aging, *Living Is For Everyone (LIFE) Framework (2007),* Australian Government, Canberra, 2008, p. 31.
[248] Department of Health, National Mental Health Strategy: The Fifth National Mental Health and Suicide Prevention Plan, Australian Government, Canberra, October 2017, p. 12.
[249] Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Australian Government, Canberra, 2013, pp. 27-28, 38-41.
[250] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, pp. 3, 28, 36, 39, 41, 44, 53-54.

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to be a focus from the growing number of Indigenous suicides and the need for multisectorial action on the collection and reporting of data.

Three main issues can be identified:

1. There is variable quality of Aboriginal and Torres Strait Islander identification at the State and national levels, resulting in an expected under-reporting of Aboriginal and Torres Strait Islander suicides.

2. Lack of reporting on suicide due to questions regarding intent, especially in the case of childhood suicides. Similarly, it can be demonstrated that there may be a reluctance to classify adult deaths as suicides for a variety of reasons also.

3. Delays in reporting data, whereby incidences of Aboriginal and Torres Strait Islander suicide might not be known for months and often years after the fact.

The delay between the timing of suicide events and their reporting is an impediment to the early detection of systematic trends (including 'suicide hotspots and clusters') and intervention responses aimed at preventing further suicides. Accessibility of real time data is an essential component in efforts to ensure that bereaved families and communities can access the services they need, and also to enable targeted interventions to prevent the development of suicide clusters.[251]

Key Action Area 6 of *Suicide Prevention 2020* is titled 'Timely data and evidence to improve responses and services' and relevantly states that:

The complexity and changing nature of suicidal behaviour necessitates that up-to-date research and evaluation measures inform and direct prevention strategies and training. Emerging trends and suicide 'hotspots' require information that is current and accurate so that services can respond appropriately.

This action area will be achieved through:

6.1 Collating, analysing and disseminating the latest research and evaluation reports on risk and protective factors and evidence- based programs.

6.2 Monitoring and evaluating initiatives for ongoing improvement.

6.3 Establishing a taskforce to monitor, improve and utilise suicide related data to inform planning, intervention and postvention responses. [252]

The early priorities for implementing Key Action Area 6 of *Suicide Prevention 2020* are:

6.1.1 The One Life WA website will continue to promote the latest research on suicide prevention and related issues.

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[251] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 2.
[252] Mental Health Commission, Government of Western Australia, *Suicide Prevention 2020: Together We Can Save Lives*, 2015, Perth, p. 43.

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6.2.1 Programs funded by the Mental Health Commission will be progressively evaluated to build the evidence base of what works.

6.3.1 The Mental Health Commission will work with the Coroner's Office, Western Australian Police and Telethon Kids Institute to establish a Suicide Prevention Data Taskforce to improve data collection, coordination, monitoring and reporting across the State. The taskforce will include relevant government agencies, services and researchers to progress the following:

- Ensure data collection aligns with national standards and is linked across coronial, police, health, child protection, education, alcohol and other drug and ambulance systems;

- Collate ambulance and hospitalisation data, and community surveys on suicide attempts and treatment to improve interventions and support recovery;

- Support data collection on high-risk groups, including Aboriginal communities, and any emerging suicide clusters to ensure appropriate responses;

- Monitor the methods for suicide and suicide attempts to ensure means restriction efforts are responsive to changing patterns; and

- Improve utilisation of data to improve suicide prevention, intervention and postvention activities.[253]

The Western Australian Branch of the Royal Australian and New Zealand College of Psychiatrists recently noted that:

> In Western Australia, the Mental Health Commission is the current contracting agency for mental health services. The Mental Health Commission must have access to comprehensive data from the Department of Health and Health Service providers regarding costs and outcomes of commissioned services. Where mental health services are integrated in the provision of health services more generally, budget and reporting systems need to support transparency regarding costs and outcomes for mental health services to ensure that mental health commissioning can be properly evaluated and that funding is not being diverted to other services.

> The Mental Health Commission must have clear and accessible processes for identifying sector concerns and responding to changing demographics, prevalence of disease and other drivers of service needs. Conversely, transparency on the behalf of the Commission regarding the modelling, planning and prioritisation of services should be considered a worthwhile exercise in transparency.[254]

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[253] Mental Health Commission, Government of Western Australia, *Suicide Prevention 2020: Together We Can Save Lives*, 2015, Perth, p. 43.
[254] Royal Australian and New Zealand College of Psychiatrists, *Submission to the Western Australian Sustainable Health Review*, 25 October 2017, viewed 14 March 2019, <https://www.ranzcp.org/files/resources/submissions/wa-sustainable-health-review-public-submission-fin.aspx>, p. 6.

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3.1.2 Reliable data regarding children and young people who died by suicide, attempted suicide and/or self-harmed is essential for effective decision making and resource allocation

Accurate, complete and timely data collection about children and young people who died by suicide, attempted suicide, and/or self-harmed, is essential to better understand the extent of suicidal and self-harming behaviour by children and young people in Western Australia. This will help to:

- efficiently allocate funding;

- identify issues for further research;

- develop appropriate prevention strategies and activities; and

- evaluate the effectiveness of prevention efforts.

ATSISPEP's discussion paper, *Real Time Suicide Data*, identifies the importance of timely data collection and concludes that:

> Without comprehensive, meaningful, timely and accessible data, all jurisdictions lack a clear understanding of the scope of suicide behaviours and hence, … the ability to take appropriate and targeted action in preventing suicides. It is also imperative that policies aimed at preventing suicide are developed based on good quality information and evidence. The design and implementation of effective preventive measures will be greatly enhanced by timely information on the characteristics of those who have suicided and the identification of possible current causative influences in specific populations in each state and territory.

> There is no doubt that work to improve the speed of availability of data, and its quality is being actively pursued locally and internationally. One can't underestimate this effort – if timely knowledge of a suicide saves just one further life, its value cannot be denied. …

> From the viewpoint of suicide of Aboriginal and Torres Strait Islander people – both for the loved ones of those left behind, and those who can be protected – effort to improve real time reporting of suicide data must be maintained.

> It is essential that:
> - Coronial decisions are clear on intention, and delivered in a timely manner;
> - Alternative mechanisms for data collection are explored, such as social media, funeral directors, etc.;
> - The ABS and NCIS continue to monitor and improve their processes;
> - National standardisation be reached on determination and reporting of suicide; and

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- Aboriginal and Torres Strait Islander people be engaged to assist in ensuring that there are improvements in identification as Indigenous Australians, and that non-Indigenous Australians approach all deaths in a culturally sensitive and appropriate manner.[255]

The issue of data collection was also recently considered by the Parliament of New South Wales Joint Committee on Children and Young People in its inquiry into *Prevention of Youth Suicide in New South Wales*, which recommended the establishment of 'a multicentre sentinel system to collect data on self-harm and suicide attempts'.[256]

3.1.3 Suicide and self-harm by children and young people in Western Australia

Chapters 3 and 4 of this volume, include the prevalence of suicide and recorded incidences of self-harm (that is, self-harm which required a hospital admission or related to an episode in an emergency department) by children and young people in Western Australia from 2009-10 to 2017-18. This is the first investigation in which this self-harm data has been presented together with data relating to deaths by suicide in Western Australia and is intended to inform future suicide prevention and child wellbeing promotion efforts in this State.

The Department of Health provided the Office with the data relating to emergency apartment attendances and admissions for all children and young people under 18 relating to self-harm,[257] and noted that:

- the data was preliminary data for the period 30 June 2009 to 18 July 2018;

- admissions data was sourced from the Hospital Morbidity Data Collection (**HMDC**) as at 18 July 2018;

- emergency department presentation data was sourced from EDIS and WebPAS as received up to 18 July 2018, and Peel Health Campus data up to 15 July 2018; and

- the HMDC data from May 2018 -18 June 2018 was not complete.

After receiving this data from the Department of Health the Office reconciled it with our own data relating to the 115 children and young people who died by suicide, omitting the following cases from our analysis:

- 12 hospital admissions during which a child or young person died;

- 2 hospital admissions in which the 'admission date' was prior to 1 July 2009;

- 133 hospital admissions in which a child or young person was discharged or transferred to another hospital for treatment as part of a single occasion of self-harm related care (that the Office instead counted as one admission to hospital, with a length of stay equal to the cumulative time spent in hospital across all facilities);

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[255] Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, pp. 8-9.
[256] Joint Committee on Children and Young People, *Prevention of Youth Suicide in New South Wales, Report 5/56*, Parliament of New South Wales, Sydney, October 2018, p. 65.
[257] That is, admissions where the ICD-10 external cause code was X60-X84 or Y87, and emergency department presentations where the 'episode diagnosis' recorded related to self-harm or suicidal ideation.

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- 2,490 emergency department presentations in which a child or young person was discharged by way of admission to a hospital for treatment;

- 76 emergency department presentations by a child aged under 6;

- 6 emergency department presentations in which a child or young person died in the emergency department; and

- 4 emergency department presentations in which the 'admission date' was prior to 1 July 2009.

The Office acknowledges the limitations of hospital admission and emergency department presentation data in providing a comprehensive picture of the extent of self-harm by children and young people in Western Australia over the investigation period. It also notes the research literature, which recognises that:

> The incidence of self-harm … can be conceptualized in terms of an iceberg model, with three levels: fatal self-harm (i.e. suicide), which is an overt but uncommon behavior (the tip of the iceberg); self-harm that results in presentation to clinical services, especially hospitals, which is also overt, but common; and self-harm that occurs in the community, which is common but largely hidden (the submerged part of the iceberg). The iceberg model is useful for clinicians, researchers, and policy makers because it conveys the hierarchical yet dynamic nature of self-harm. Establishing the relative incidence of self-harm at these three levels is important to understand the extent of the problem and to identify the challenges for prevention and intervention.[258]

The Office estimated the extent of unreported self-harming behaviour by children and young people in Western Australia using ABS population data and published community survey data to contextualise our presentation of the data obtained from the Department of Health as part of the iceberg model of self-harm (Figure 14).

The Office's methodology in calculating the extent of unreported self-harm by children and young people in Western Australia draws upon findings from research survey data, indicating that:

- around 6 per cent for 14 and 15 year old young people engaged in self-harming behaviour in the 12 months prior to recent English research;[259]

- between 7 to 8 per cent of children and 20 to 37 per cent for 14 to 16 year old young people in the United States have self-harmed in their lifetime; [260] and

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[258] Geulayov G et al, 'Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study', *Lancet Psychiatry*, vol. 5, no. 2, February 2018, pp. 167-174, 167-168. See also: Hawton K, Saunders KEA, O'Connor RC, 'Self-harm and suicide in adolescents', *Lancet*, vol. 379, no. 9834, June 2012, pp. 2373-2382; McMahon EM, et al, 'The iceberg of suicide and self-harm in Irish adolescents: a population-based study', *Social Psychiatry and Psychiatric Epidemiology*, vol. 49, no. 12, December 2014, pp. 1929-1935.

[259] Hawton K, et al, 'Deliberate self harm in adolescents: self report survey in schools in England', *BMJ Open*, vol: 325, no. 325 e:1207, November 2002, doi: 10.1136/bmj.325.7374.1207.

[260] Darganova G, 'Self-harm and suicidal behaviour of young people aged 14-15 years old', in *The Longitudinal Study of Australian Children Annual Statistical Report 2016*, Australian Institute of Family Studies, Australian Government, August 2017.

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- approximately 'one in 10 12-17 year-olds (10.9%) reported having ever self-harmed' in the second Australian Child and Adolescent Survey of Mental Health and Wellbeing.[261]

Taking this research literature into account, the Office used an approximate prevalence rate of 10.9 per cent (of the 482,235 individuals aged between 10 and 17 years in Western Australia from 1 July 2009 – 30 June 2018) to estimate the total number of children and young people that self-harmed. The Office then subtracted the total number of known children and young people who died by suicide or were treated in hospital for suicidal behaviour or self-harm.

Figure 14: Suicide and self-harm by children and young people in Western Australia, 1 July 2009 – 30 June 2018

115 children and young people died by suicide (0.02 per cent)

3,716 children and young people admitted to hospital (0.77 per cent)

9,950 children and young people attended a public hospital emergency deparment (2.06 per cent)

An estimated 38,783 children and young people self-harmed but were not treated in a hospital
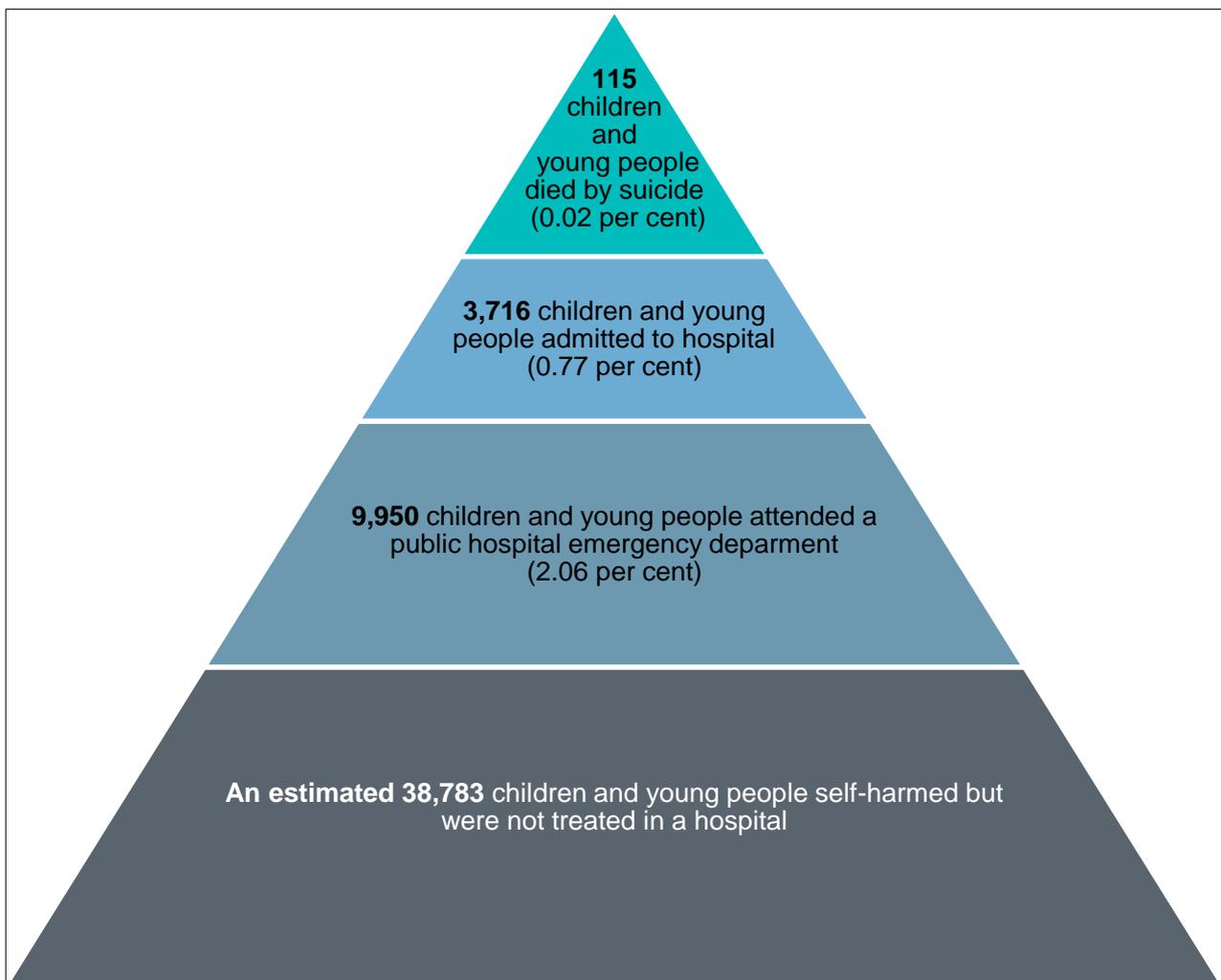
Source: Ombudsman Western Australia

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[261] Lawrence D et al, The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra, 2015.

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3.2 Children and young people whose deaths were notified to the Ombudsman

3.2.1 The Ombudsman's Child Death Review role

The Department of Communities receives information from the State Coroner on reportable sudden 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 of Communities by the State Coroner about the circumstances of the child's death together with a summary outlining the Department of Communities' past involvement with the child.

3.2.2 The 2014 Investigation

As outlined in Chapter 1.1.1 of this volume, the 2014 Investigation analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner had 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 had not yet completed an investigation). Of these 36 young people:

- 13 young people (36 per cent) were recorded as identifying as Aboriginal or Torres Strait Islander, and 23 young people were non-Aboriginal or Torres Strait Islander;

- 20 young people (56 per cent) were recorded as allegedly experiencing one or more forms of child abuse and neglect, including sexual abuse, physical abuse, neglect, or emotional abuse (including exposure to family and domestic violence); and

- 22 young people (61 per cent) were male and 14 young people (39 per cent) were female.

- All 36 young people who died by suicide whose lives were considered as part of the 2014 Investigation were 14 to 17 years at the time of their death, 89 per cent of whom were 15 to 17 years.

3.2.3 Since the 2014 Investigation, suicide has continued to be the leading cause of death for young people aged 13 to 17 years and an increasing cause of death for children aged 6 to 12 years

The Ombudsman Western Australia *Annual Report 2017-18*[262] identifies that suicide by children was the subject of:

- 5 per cent of child death notifications for children 6 to 12 years (5 of 90 notifications); and

- 13 per cent of the investigable deaths of children 6 to 12 years (4 of 31 deaths).

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[262] Ombudsman Western Australia, *Annual Report 2017-18*, Ombudsman WA, Perth, September 2018.

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Additionally, suicide has continued to be the leading circumstance of investigable and non-investigable deaths of young people aged 13 to 17 years notified to the Office between 1 July 2009 and 30 June 2018, representing:

- 44 per cent of the total child death notifications for young people aged 13 to 17 (112 of 256 notifications); and

- 53 per cent of investigable deaths of young people aged 13 to 17 (59 of 107 deaths).

3.2.4 Aboriginal children and young people continue to be very significantly overrepresented in the 79 of children and young people who died by suicide in Western Australia during the 2020 Investigation

As identified in the Ombudsman Western Australia *Annual Report 2017-18*[263] (and discussed further in Chapter 6 of this volume) Aboriginal and Torres Strait Islander children and young people remain significantly overrepresented in the number of child death notifications received by the Office concerning apparent suicide, accounting for:

- 20 per cent of child death notifications in which a child or young person was identified as Aboriginal and/or Torres Strait Islander (39 of 194 notifications);

- 44 per cent of child death notifications concerning children and young people who died in circumstances of apparent suicide (39 of 88 deaths by apparent suicide where information about a child or young person's Aboriginal identity was available); and

- 66 per cent of investigable deaths in circumstances of apparent suicide.

By way of comparison, Aboriginal and/or Torres Strait Islander children and young people comprise 6 per cent of the Western Australian population of children and young people.

3.2.5 The 2020 investigation analysed the deaths of 79 children and young people who died by suicide

Further to the Office's consideration of the steps taken by State government departments and authorities to give effect to the recommendations arising from the 2014 Investigation, during the 2020 Investigation, the Office analysed records relating to 79 children and young people during the who, either:

- died by suicide (for those deaths where the State Coroner had completed an investigation and found that the cause of death was suicide or made an open finding that suicide may have been the cause of death); or

- were suspected of having died by suicide (for those deaths where the State Coroner had not yet completed an investigation).

Of the 79 children and young people:

- 30 children and young people (38 per cent) were recorded as identifying as Aboriginal or Torres Strait Islander, and 49 children and young people (62 per cent) were non-Aboriginal;

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[263] Ombudsman Western Australia, *Annual Report 2017-18*, Ombudsman WA, Perth, September 2018.

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- 49 children and young people (62 per cent) were recorded as allegedly experiencing one or more forms of child abuse and neglect, including sexual abuse, physical abuse, neglect, or emotional abuse (including exposure to family and domestic violence);

- 62 young people (78 per cent) were between the ages of 15 and 17 years at the time of their death; and

- 50 children and young people were male (63 per cent) and 29 children and young people were female (37 per cent).

3.2.6 Eleven Western Australian children died by suicide during the 2020 Investigation period. Ten of these children had allegedly experienced child abuse or neglect and were known to the Department of Communities prior to their death

Eleven of the 79 children and young people (14 per cent) were children aged between 10 and 13 years at the time of their death, including seven female children (64 per cent) and four male children (36 per cent) (referred to as **the 11 children**).

Significantly, records reviewed during the 2020 investigation indicate that 10 of the 11 children (91 per cent) had allegedly experienced child abuse or neglect and were known to the Department of Communities in relation to these allegations. Further details regarding the Office's analysis of these 11 children are provided Chapter 7.2 of this volume.

3.2.7 The 2020 investigation also considered the characteristics of all 115 children and young people who died by suicide in Western Australia from 1 July 2009 to 30 June 2018

In this report, the totality of children and young people who died by suicide in Western Australia from 1 July 2009 to 30 June 2018 are referred to as the 115 children and young people. Of the 115 children and young people, records indicate that 43 identified as Aboriginal or Torres Strait Islander (37 per cent).

3.3 Prevalence of suicide by children and young people

The World Health Organization estimates that, in 2016, suicide accounted for 1.4 per cent of all deaths worldwide, globally accounting for 800,000 deaths per annum, at a global age-standardised death rate of 10.5 per 100,000 and was the 18th leading global cause of death.[264]

Since 2000, the overall global age-specific death rate by suicide has declined from 13.9 deaths per 100,000 people to 10.5 deaths per 100,000 people in 2016.[265]

Across countries in the Organisation for Economic Co-operation and Development (**OECD**), suicide rates for young people aged from 15 to 19 years have also declined

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[264] World Health Organization, *Mental health: Suicide data,* WHO, viewed 14 March 2019,
<http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/>.
[265] World Health Organization, *Disease burden and mortality estimates*, WHO, viewed 14 March 2019,
<www.who.int/healthinfo/global_burden_disease/estimates/en/>.

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slightly from 8.5 deaths per 100,000 in 1990, to 7.4 deaths per 100,000 in 2015.[266] However, in the United States suicide rates for young people have recently increased 'against the backdrop of generally declining mortality'[267] from:

- 0.5 deaths per 100,000 children and young people aged 10-14 years in 1999 to 1.5 deaths per 100,000 children and young people aged 10-14 years in 2014;[268] and

- 3 deaths per 100,000 young people aged 15-24 years in 1999 to 4.6 deaths per 100,000 young people aged 15-24 years in 2014.[269]

In Australia, the highest recorded rates of death by suicide occurred in 1930 and the early 1960s.[270] The most recent peak occurred in 1997 (14.7 per 100,000).[271] Since 1997, the age-specific rate of death by suicide has varied from a high of 12.9 per 100,000 in 2015 to a low of 10.4 per 100,000 in 2005 (Figure 15).

Figure 15: Australian and global suicide rates 1997 to 2017, by year
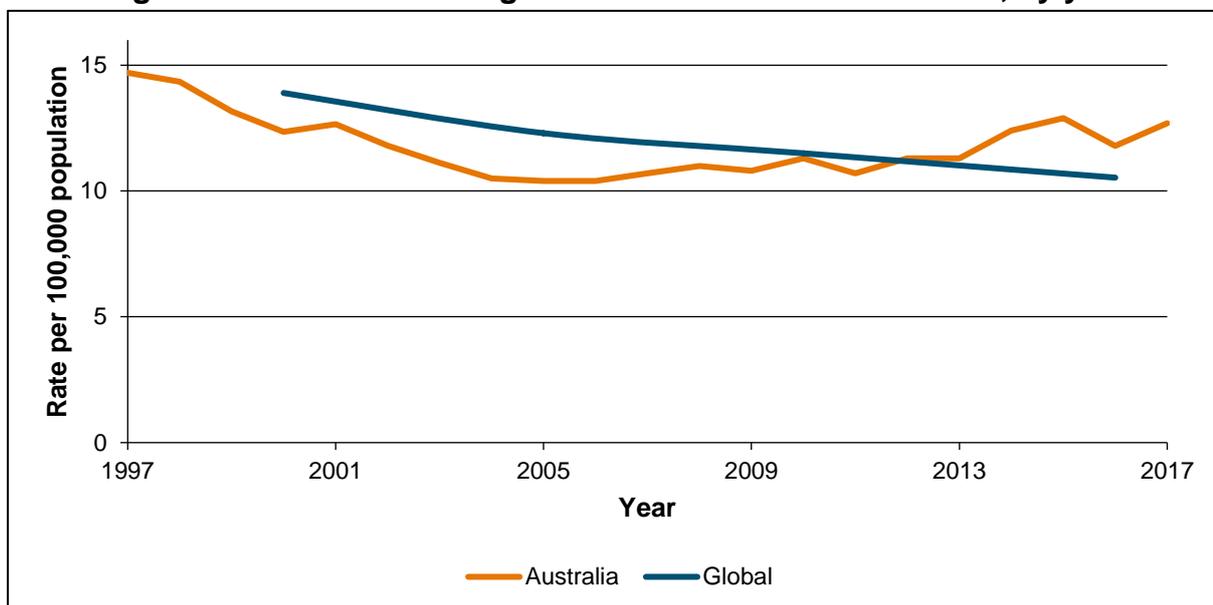
Source: World Health Organization[272]; ABS[273]

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[266] Organisation for Economic Co-operation and Development, *OECD Family Database: CO4.4: Teenage suicides (15-19 years old)*, viewed 5 September 2018, <www.oecd.org/els/family/database.htm>.

[267] National Center for Health Statistics, *Increase in Suicide in the United States, 1999-2014, NCHS Data Brief No. 241,* April 2016, viewed 5 September 2018, <https://www.cdc.gov/nchs/products/databriefs/db241.htm>.

[268] National Center for Health Statistics, *Increase in Suicide in the United States, 1999-2014, NCHS Data Brief No. 241,* April 2016, viewed 5 September 2018, <https://www.cdc.gov/nchs/products/databriefs/db241.htm>.

[269] National Center for Health Statistics, *Increase in Suicide in the United States, 1999-2014, NCHS Data Brief No. 241,* April 2016, viewed 5 September 2018, <https://www.cdc.gov/nchs/products/databriefs/db241.htm>.

[270] Australian Broadcasting Corporation, *Historical rate of death by suicide per 100,000 people, 1921-2010*, ABC, 8 October 2015, viewed 14 March 2019, <http://www.abc.net.au/news/2015-10-08/suicide-historical-chart-fact-check/6834466>.

[271] Australian Bureau of Statistics, *Australian Social Trends, 2000: Mortality and Morbidity*, cat. no. 4102.0, ABS, Canberra, 2000; Snowdon J, 'Why have Australian suicide rates decreased?', *Australian and New Zealand Journal of Psychiatry*, vol. 50, no. 1, January 2016, pp. 13-15.

[272] World Health Organization, *Disease burden and mortality estimates*, WHO, Geneva, viewed 14 March 2019, <www.who.int/healthinfo/global_burden_disease/estimates/en/>.

[273] Australian Bureau of Statistics, *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018; Australian Bureau of Statistics, 'Mortality and Morbidity', *Australian Social Trends, 2000,* cat. no. 4102.0, ABS, Canberra, July 2000.

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The Western Australian suicide rate for people of all ages (14.7 per 100,000) is higher than the equivalent national rate (12.1 per 100,000).[274] Similarly, Western Australian children and young people between the ages of 5 and 17 years die by suicide at a higher rate (3.4 per 100,000) than the average rate experienced across all Australian states and territories (2.4 per 100,000).[275]

Statistics, such as suicide rates, are an imperfect measure of the effects that premature mortality caused by suicide have on our society, as acknowledged by the ABS:

> Counts of death provide one measure of the impact of particular diseases, but they do not take into account the ages at which deaths occur. Years of Potential Life Lost (YPLL) measures the extent of 'premature' mortality from particular diseases or trauma, counting the total number of years between age at death and an 'average' life expectancy for deaths that occur before that average age.[276]

> In Australia, suicide is 'the greatest contributor to potential years of life lost' and the leading cause of premature mortality for people 15 to 44 years.[277]

This Office's analysis of the 115 children and young people found that their premature deaths equated to over 7,000 years of potential life lost, in addition to the immeasurable ongoing impact of these premature deaths on the families, friends and communities of the 115 children and young people.[278]

3.4 Circumstances in which children and young people died by suicide

Child death review notifications received by the Ombudsman include general information about the circumstances of death. This is an initial indication of how a child or young person may have died, but is not the cause of death, which can only be determined by the Coroner.

Summary of the circumstances in which children and young people died by suicide in Western Australia between 2009-10 and 2017-18.

Figure 16, below, summarises the circumstances of death for each of the 115 children and young people.

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[274] Australian Bureau of Statistics, 'Table 11.6 - Intentional self-harm, State and territory, Number of deaths, Age-standardised death rate, Rate ratio, Sex, 2008-2017', Causes of Death, Australia, 2017, cat. no. 3303.0, ABS, Canberra, September 2018; Australian Bureau of Statistics, 'Table 11.2 - Intentional self-harm, Age-specific death rates, 5 year age groups by sex, 2008-2017', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

[275] Australian Bureau of Statistics, 'Table 11.11 - Intentional self-harm, Number of deaths in children aged 5-17 years by age, state and territory of usual residence, 2013-2017', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

[276] Australian Bureau of Statistics, 'Australia's leading causes of death, 2017', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

[277] Australian Institute of Health and Welfare, *Australia's Health 2016: 3.2 Premature Mortality*, 2016, AIHW.

[278] Based on an average life expectancy of 83.1 years for non-Aboriginal female people, 79.7 years for non-Aboriginal male people, 73.7 years for female Aboriginal people and 69.1 for male Aboriginal people: Australian Institute of Health and Welfare, *Deaths in Australia*, AIHW, 18 July 2018, viewed 14 March 2019, <https://www.aihw.gov.au/reports/life-expectancy-death/deaths/contents/life-expectancy>.

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Figure 16: Circumstances of death, for the 115 children
and young people, by Ombudsman Investigation

Circumstances of death	2014 Investigation 36 young people	2020 Investigation 79 children and young people	2009-10 to 2017-18 Western Australia 115 children and young people
Method of suicide			
Hanging	32 (89%)	66 (84%)	98 (85%)
Other	4 (11%)	13 (16%)	17 (15%)
Location of suicide			
Child or young person's home	22 (61%)	54 (68%)	76 (66%)
Public place	7 (20%)	18 (23%)	25 (22%)
Friend, relative or neighbour's property	4 (11%)	5 (6%)	9 (8%)
Other	3 (8%)	2 (3%)	5 (4%)
Month of suicide			
January	2 (6%)	8 (10%)	10 (9%)
February	2 (6%)	3 (4%)	5 (4%)
March	4 (11%)	12 (15%	16 (14%)
April	3 (8%)	7 (9%)	10 (9%)
May	3 (8%)	6 (8%)	9 (8%)
June	1 (3%)	6 (8%)	7 (6%)
July	5 (14%)	6 (8%)	11 (10%)
August	3 (8%)	5 (6%)	8 (7%)
September	2 (6%)	3 (4%)	5 (4%)
October	3 (8%)	4 (5%)	7 (6%)
November	5 (14%)	8 (10%)	13 (11%)
December	3 (8%)	11 (14%)	14 (12%)

Source: Ombudsman Western Australia

3.4.1 Method of suicide

International and national research literature identifies hanging as the most common suicide method for young people.[279]

In Western Australia, hanging was the most common method of death among the 115 children and young people (98 children and young people or 85 per cent), followed by jumping or lying in front of a moving object (5 young people, or 4 per cent).

3.4.2 Location of suicide

Among the 115 children and young people, the most common location of death was their home. Seventy-six children and young people died in their own home and nine children and young people (8 per cent) died at a friend, relative or neighbour's property. Twenty-five children and young people (22 per cent) died in public places such as parks, school grounds, transport areas and community buildings, including four young people (3 per cent) who died at a rail transport location (Figure 17).

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[279] Värnik A et al, 'Suicide methods in Europe: a gender-specific analysis of countries participating in the European Alliance Against Depression', *Journal of Epidemiology and Community* Health, vol 62, no. 6, June 2008, pp. 545-551; Australian Bureau of Statistics, 'Table 11.4 - Intentional self-harm by Indigenous status, 2012-2016', *Causes of Death, Australia, 2016*, cat. no. 3303.0, ABS, Canberra, September 2017.

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Figure 17: Location of suicide, for the 115 children and young people
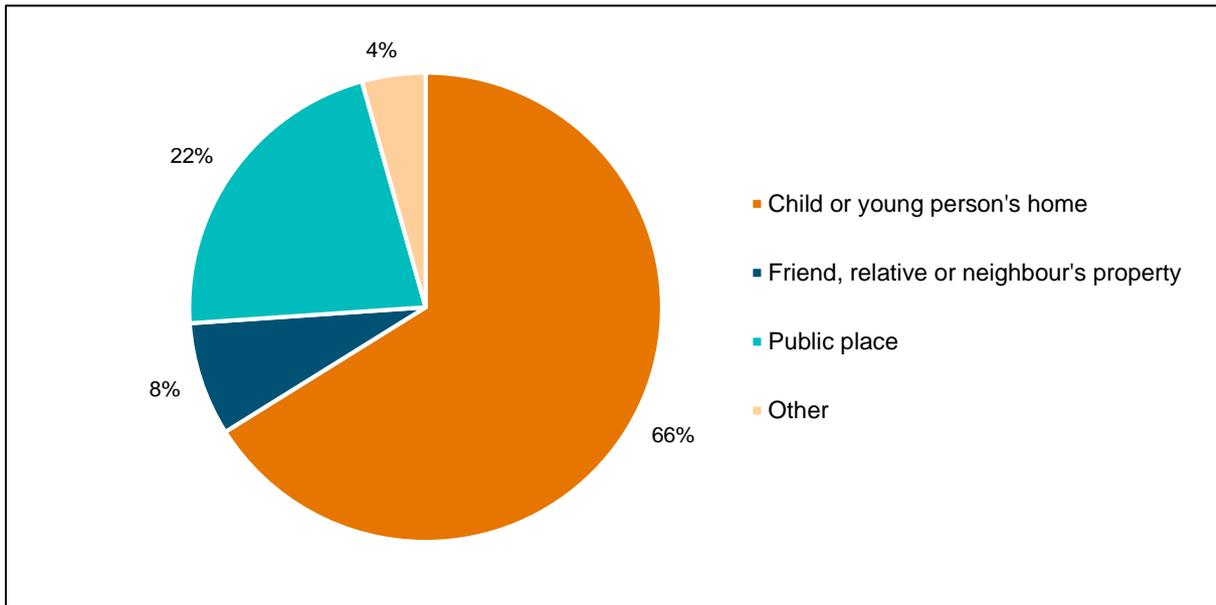
Source: Ombudsman Western Australia

3.4.3 Month of suicide

Figure 18 shows the number of deaths in each calendar month, for the 115 children and young people. Deaths by suicide occurred most frequently in the months of March, December and November, and were least frequent in February and September.

Figure 18: Month of suicide, for the 115 children and young people

Source: Ombudsman Western Australia

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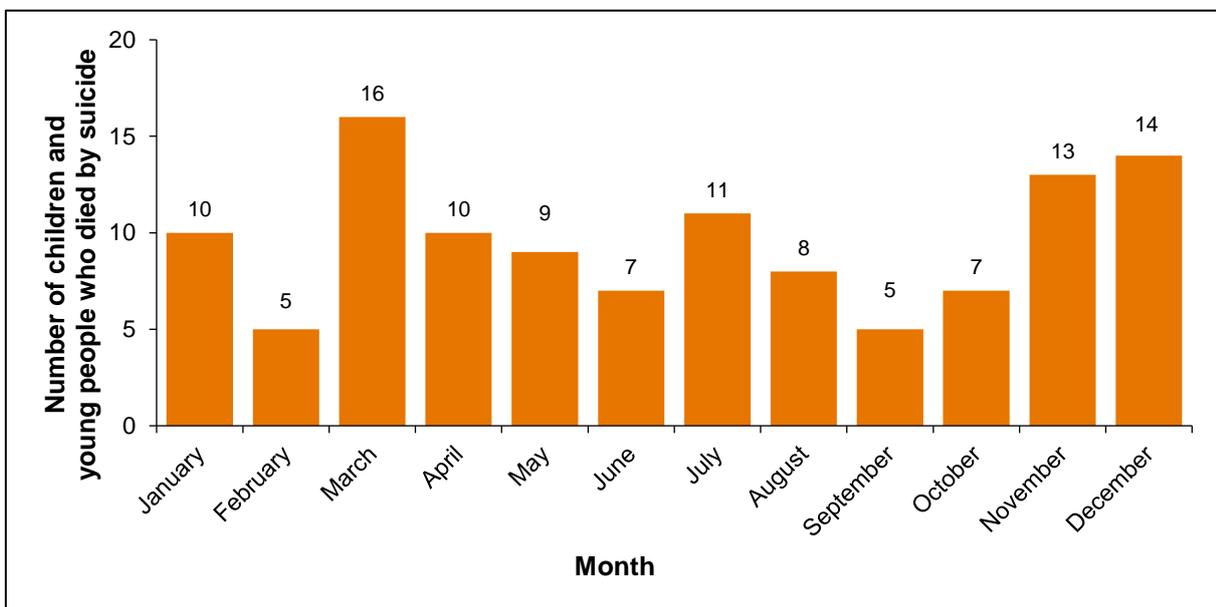
3.5 Characteristics of children and young people who died by suicide

The Office used information obtained from the Mental Health Commission, the Department of Health, Child and Adolescent Health Service, Western Australian Country Health Service, the Department of Communities and the Department of Education to identify the demographic characteristics of the 115 children and young people.

The research literature discussed in the 2014 Investigation Report and in Chapter 2 of this volume, identifies a range of risk factors, warning signs and precipitating events associated with suicide by children and young people. These risk factors, warning signs and precipitating events are referred to in this report as factors associated with suicide. While no single cause of suicide has been identified, 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. The Office also used the information collected to identify the factors associated with suicide experienced by the 115 children and young people.

Figure 19 lists the demographic characteristics and factors associated with suicide that were identified and analysed during the 2020 Investigation.

Figure 19: Demographic characteristics and factors associated with suicide, discussed in this report

Demographic characteristics	
• Age	• Aboriginal status[280]
• Sex	• Region of residence
• Country of birth	• Experience of homelessness

Factors associated with suicide	
• Mental health conditions	• Neglect
• Self-harming behaviour	• Parent living with one or more mental health conditions
• Suicidal ideation	• Parent experiencing problematic drug and alcohol use
• Communicated suicidal intent	
• Previous suicide attempts	• Parent imprisoned
• Family and domestic violence	• Family member, friend or person known to the young person died by suicide
• Sexual abuse	
• Physical abuse	• Alcohol or other drug use
• Sexuality and gender identity	• Use of social media

Additional factors associated with suicide by Aboriginal children and young people	
• Trauma and intergenerational trauma	• Removal from parents and community
• Disempowerment	• Racism

Source: Ombudsman Western Australia

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[280] As noted at section 3.2.3, Aboriginal children and young people experience elevated rates of suicide.

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3.5.1 Summary of the demographic characteristics of children and young people who died by suicide in Western Australia between 2009-10 and 2017-18

Figure 20 summarises the demographic characteristics of the 115 children and young people, the 43 children and young people who died by suicide (Chapter 6.4.2 of this volume) during the 2020 Investigation and identified as Aboriginal or Torres Strait Islander (**the 43 Aboriginal and Torres Strait Islander children and young people**), the 11 children who died by suicide (Chapter 7.2.2 of this volume) and each of the four groups of children and young people identified in the 2014 Investigation (Chapters 7.2.2, 7.3.2, 7.4.2 and 7.5.2 of this volume).

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Figure 20: Demographic characteristics, for the
115 children and young people, by Ombudsman Investigation

Demographic Characteristics	2014 Investigation 36 young people	2020 Investigation 79 children and young people	2009-10 to 2017-18 Western Australia 115 children and young people
Age			
10 to 13 years	0 (0%)	11 (14%)	11 (10%)
14 years	4 (11%)	6 (8%)	10 (9%)
15 years	10 (28%)	15 (19%)	25 (22%)
16 years	10 (28%)	18 (23%)	28 (24%)
17 years	12 (33%)	29 (37%)	41 (36%)
Sex			
Male	22 (61%)	50 (63%)	72 (63%)
Female	14 (39%)	29 (37%)	43 (37%)
Remoteness of residence			
Major Cities	23 (64%)	43 (54%)	66 (57%)
Inner Regional	3 (8%)	9 (11%)	12 (10%)
Outer Regional	4 (11%)	6 (8%)	10 (9%)
Remote and Very Remote	6 (17%)	21 (27%)	27 (23%)
Total regional and remote	13 (36%)	36 (46%)	49 (43%)
Region of residence as a percentage of the 115 children and young people			
Greater Perth			52%
Gascoyne			2%
Goldfields Esperance			6%
Great Southern			2%
Kimberley			17%
Mid West			3%
Peel			4%
Pilbara			2%
South West			9%
Wheatbelt			3%
Aboriginality			
Aboriginal and Torres Strait Islander	13 (36%)	30 (38%)	43 (37%)
Male	6 (46%)	16 (53%)	22 (51%)
Female	7 (54%)	14 (47%)	21 (49%)
Non-Aboriginal	23 (64%)	49 (62%)	72 (63%)
Socioeconomic disadvantage (by State SEIFA Quintile rank)[281]			
Quintile 1 (Most Disadvantaged)	8 (22%)	28 (35%)	36 (31%)
Quintile 2	7 (19%)	14 (18%)	21 (18%)
Quintile 3	6 (17%)	12 (15%)	18 (16%)
Quintile 4	8 (22%)	11 (14%)	19 (17%)
Quintile 5 (Least Disadvantaged)	7 (19%)	14 (18%)	21 (18%)
Mean SEIFA score	975	959	964

Source: Ombudsman Western Australia

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[281] Socio-Economic Indexes for Areas rank geographic areas in terms of their socioeconomic characteristics. The Office assigned scores from the ABS 2016 Index of Relative Disadvantage (IRD) SEIFA based on residential postcode at the time of death. Quintiles were also assigned based upon the State-based decile ranks. Scores lower than 1000 indicate areas with disadvantaged socio-economic characteristics but do not convey any information about individual a child, young person or their family's socioeconomic status.

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3.5.2 Age

3.5.2.1 *Global*

The World Health Organization identifies that for young people 15 to 29 years:

> … suicide accounts for 8.5% of all deaths and is ranked as the second leading cause of death (after traffic accidents). Among adults aged 30-49 years it accounts for 4.1% of all deaths and is ranked the fifth leading cause of death.[282]

World Health Organization data also indicates a declining rate of suicide by 15 to 29 year olds (from a crude death rate of 15.1 per 100,000 in 2000 to 11.8 per 100,000 in 2016) over 16 years to 2016 for and a relatively constant rate of suicide by 5 to 14 year olds (from a crude death rate of 1.0 per 100,000 in 2000 to 0.8 per 100,000 in 2016).[283]

Population studies of suicide rates for children and young people from 1990 to 2009 in 81 countries, relevantly identify that:

- for children and young people 10 to 14 years, the average rate had not significantly changed between 1990 and 2009, and the estimated global suicide rate for this age group in 2009 was 1.5 per 100,000 for male children and young people and 0.9 per 100,000 for female children and young people;[284] and

- for young people 15 to 19 years, overall rates had declined and the estimated global suicide rate for 2009 was 9.5 per 100,000 for male children and young people and 4.2 per 100,000 for female children and young people.[285]

Although global suicide by young people rates appear to be decreasing, and some countries report similarly declining rates,[286] other countries have recently reported increases in rates. For example, in the United States, suicide rates for people aged between 10 to 24 years have increased from 6.8 deaths per 100,000 in 2000 to 10.6 in 2017.[287]

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[282] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p 22.

[283] Calculated from population figures: World Health Organization, *Global Health Estimates 2016 Summary Tables: Global Deaths by Cause, Age and Sex, 2000-2016*, WHO, April 2018, viewed 14 March 2019 <http://www.who.int/healthinfo/global_burden_disease/estimates/en/>.

[284] Kõlves K, and De Leo D, 'Suicide rates in children aged 10-14 years worldwide: changes in the past two decades', 2014, *The British Journal of Psychiatry*, vol. 205, no. 4, October 2014, pp. 283-285.

[285] Kõlves K, and De Leo D, 'Adolescent Suicide Rates Between 1990 and 2009: Analysis of Age Group 15-19 Years Worldwide', *Journal of Adolescent Health*, vol. 58, no. 1, January 2016, pp. 69-77.

[286] See, for example: Laido Z, et al, 'Epidemiology of suicide among children and adolescents in Austria, 2001-2014', *Wiener klinische Wochenschrift*, vol. 129, no. 3, October 2014, doi: 10.1007/s00508-016-1092-8, pp. 121-128; World Health Organization, *Preventing suicide: a global imperative*, WHO, Luxembourg, 2014, p. 23; Office for National Statistics, *Statistical Bulletin: Suicides in the UK: 2017 registrations*, 4 September 2018, viewed 14 March 2019, <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesin theunitedkingdom/2017registrations>.

[287] National Center for Health Statistics, *Death Rates Due to Suicide and homicide Among Persons Aged 10-24: United States, 2000-2017, NCHS Data Brief No. 352*, October 2019, viewed 14 February 2020, <https://www.cdc.gov/nchs/products/databriefs/db241.htm>.

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3.5.2.2   Australia

Suicide is the leading cause of death among Australian children and young people between 5 and 17 years of age.[288] As shown in Figure 21, suicide is also the leading cause of death for young people between the ages of 15 and 19 years (40.3 per cent of deaths)[289] including:

- 43.4 per cent of the total deaths of 15 to 19 year old male young people; and

- 34 per cent of the total deaths of 15 to 19 year old female young people.

By comparison, suicide accounted for 1.9 per cent of all deaths in Australia and was the 14th ranked leading cause of death in 2018.

Figure 21: Deaths by suicide as a proportion of total Australian deaths, 5 year age groups by sex, 2018
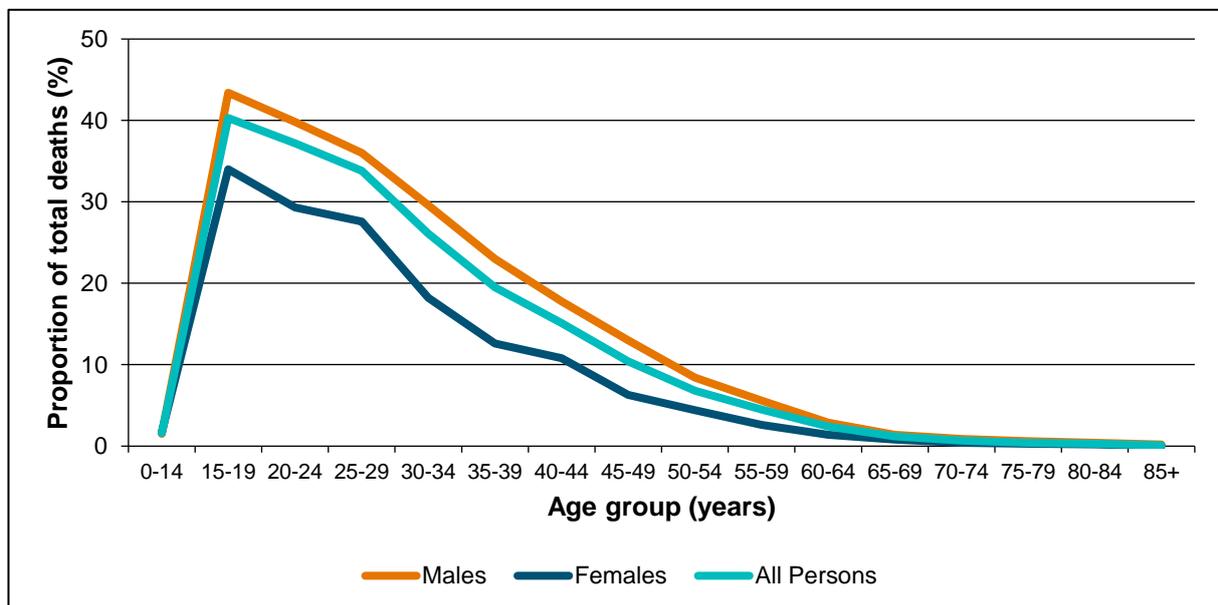
Source: ABS[290]

Age-specific rates enable trend analysis, comparisons over time and between jurisdictions, and demonstrate 'how suicide manifests across age cohorts by relating the number of deaths to the size and structure of the underlying population.'[291]

Over the decade from 2009 to 2018 (inclusive), the Australian age-specific rate of deaths by suicide for 0 to 14 year olds remained relatively stable at an average of 0.4 per 100,000

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[288] ABS, 'Intentional self-harm, key characteristics', *3303.0 – Causes of Death, Australia, 2018*, Canberra, September 2019, accessed 15 February 2020, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018 ~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>.

[289] Australian Bureau of Statistics, 'Table 11.8 Intentional self-harm, Proportion of total deaths, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2019.

[290] Australian Bureau of Statistics, 'Table 11.8 Intentional self-harm, Proportion of total deaths, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2019.

[291] ABS, 'Intentional self-harm, key characteristics', *3303.0 – Causes of Death, Australia, 2018*, Canberra, September 2019, accessed 15 February 2020, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018 ~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>.

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per year (with the number of deaths ranging from three in 2009 to 24 in 2017).[292] This increase in the number of deaths by suicide of children and young people between the ages of 0 and 14 years, has had little effect on the age-specific rate as the overall number of deaths remains a very small proportion of the population.

In contrast, over the same time period, the age-specific rate for deaths by suicide of 15 to 19 year olds increased from 7.2 per 100,000 in 2009, to 12.3 per 100,000 in 2018 (with the number of deaths ranging from 105 in 2009 to 184 in 2018).[293]

Since 2015, the ABS has published new data series for deaths by suicide among Australian 5 to 17 year olds in five year periods.

From 2014 to 2018, 467 Australian children and young people between the ages of 5 and 17 years died by suicide (a yearly average of 93 deaths or age-specific rate of 2.4 per 100,000 population), including 98 children and young people between the ages of 5 and 14 years (21 per cent) and 369 young people between the ages of 15 and 17 years (79 per cent).[294]

Accordingly, the age-specific rate of deaths by suicide for the 15 to 17 year age group was higher (8.5 per 100,000) than the 5 to 14 year age group (0.7 per 100,000). Despite suicide accounting for a high proportion of total deaths of children and young people, the highest rates of death by suicide are found in older age groups, as noted by the ABS:

> The highest proportion of suicide deaths occur among young and middle aged people, while the proportion decreases in progressively older age cohorts. More than half of all suicide deaths in 2018 (54.8%) occurred between the ages 30 and 59. The median age at death for suicide was 44.4 years of age, compared to 81.7 years of age for all deaths.[295]

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[292] Australian Bureau of Statistics, 'Table 11.1 - Intentional self-harm, Number of deaths, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2018; Australian Bureau of Statistics; Australian Bureau of Statistics 'Table 11.2 - Intentional self-harm, Age-specific death rates, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2019.
[293] Australian Bureau of Statistics, 'Table 11.1 - Intentional self-harm, Number of deaths, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2018; Australian Bureau of Statistics; Australian Bureau of Statistics 'Table 11.2 - Intentional self-harm, Age-specific death rates, 5 year age groups by sex, 2098-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2019.
[294] Australian Bureau of Statistics, 'Table 11.10 - Intentional self-harm, Number of deaths in children aged 5-17 years by age and sex, Australia, 2014-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0, ABS, Canberra, September 2019.
[295] Australian Bureau of Statistics, 'Intentional self-harm, key characteristics', *3303.0 – Causes of Death, Australia, 2018*, Canberra, September 2019, accessed 15 February 2020, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>.

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Figure 22: Five year age-specific rate, suicide by children and young people aged 5 to 17 years, between 2010-14 and 2014-18, Australia, by age group
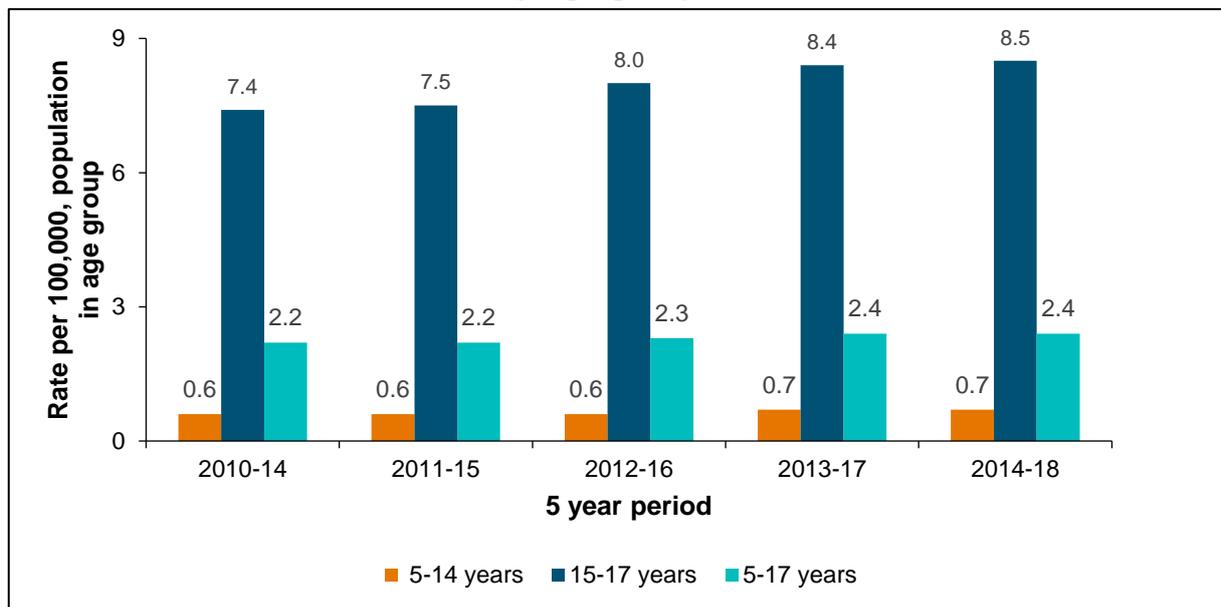
Source: ABS[296]

The ABS also publishes suicide rates for Australian states and territories in five year periods. For the 2014 to 2018 five year period, Western Australia had the:

- second highest age-specific rate of death by suicide for children and young people aged 5 to 14 years (0.9 deaths per 100,000);

- second highest age-specific rate of death by suicide for young people aged 15 to 17 years (10.8 deaths per 100,000); and

- third highest age-specific rate of death by suicide for children and young people aged 5 to 17 years (3.1 per 100,000). (Figure 23)

Western Australia's age-specific rate of deaths by suicide for 15 to 17 year old young people was almost 30 per cent higher than the equivalent national rate (8.5 deaths per 100,000).[297]

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[296] Australian Bureau of Statistics, 'Table 11.10 - Intentional self-harm, Number of deaths in children aged 5-17 years by age and sex, Australia', *Causes of Death, Australia, 2016-2018*, cat. no. 3303.0, ABS, Canberra, September 2017-19; Australian Bureau of Statistics, 'Table 11.9 Intentional self-harm, Number of deaths in children aged 5-17 years by age and sex, Australia', *Causes of Death, Australia, 2014-2015*, cat. no. 3303.0, ABS, Canberra, September 2015-17.

[297] Australian Bureau of Statistics, 'Table 11.11 - Intentional self-harm, Number of deaths in children aged 5-17 years by age, state and territory of usual residence, 2014-2018', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2019.

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Figure 23: Age-specific rate, suicide by children and young people aged 5 to 17 years, Australia, between 2014 and 2018, by state and territory and age group
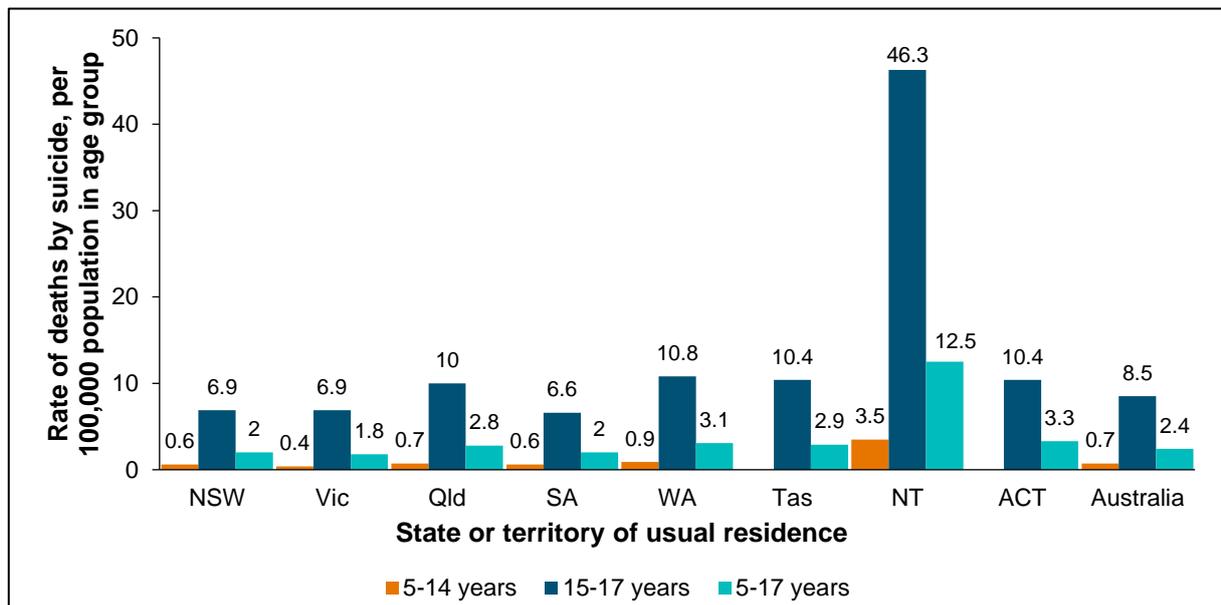
Source: ABS[298]

3.5.2.3   Western Australia

Suicide was the leading cause of death of people aged between 15 to 24 years in Western Australia in 2018, accounting for 51 deaths in this age group (38 per cent).[299] In contrast, transport accidents accounted for 34 deaths (25 per cent).[300] During the 2014 Investigation, the Office analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner had 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 had not yet completed an investigation). Each of the 36 young people were between 14 and 17 years old at the time of their death.

During the 2020 Investigation period, 79 children and young people died by suicide in Western Australia, with an average of 14 deaths per year. Eleven children aged between 10 and 13 years died by suicide during the 2020 Investigation period. Together, the 115 children and young people accounted for 15 per cent of the 783 child death notifications received by the Ombudsman in the 9 years from 1 July 2009 to 30 June 2018, including:

- 44 per cent of the child death notifications received relating to 13 to 17 year old young people; and

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[298] Australian Bureau of Statistics, 'Table 11.11 - Intentional self-harm, Number of deaths in children aged 5-17 years by age, state and territory of usual residence, 2014-2018', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2019.

[299] Australian Bureau of Statistics, 'Table 6.3 - Underlying cause of death, Selected causes by age at death, numbers and rates, Western Australia, 2017', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

[300] Australian Bureau of Statistics, 'Table 6.3 - Underlying cause of death, Selected causes by age at death, numbers and rates, Western Australia, 2017', *Causes of Death, Australia, 2017*, cat. no. 3303.0, ABS, Canberra, September 2018.

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- 5 per cent of the child death notifications received relating to 6 to 12 year old children.[301]

The 115 children and young people ranged in age from 10 to 17 years at the time of their death, with most aged between 15 and 17 years (94 young people, 82 per cent). The lowest proportion of deaths by suicide occurred among children between the ages of 10 and 12 years, with the number of deaths increasing in progressively older age groups, and most deaths by suicide occurring among 17 year old young people (Figure 24).

Figure 24: Age at time of death, for the 115 children and young people
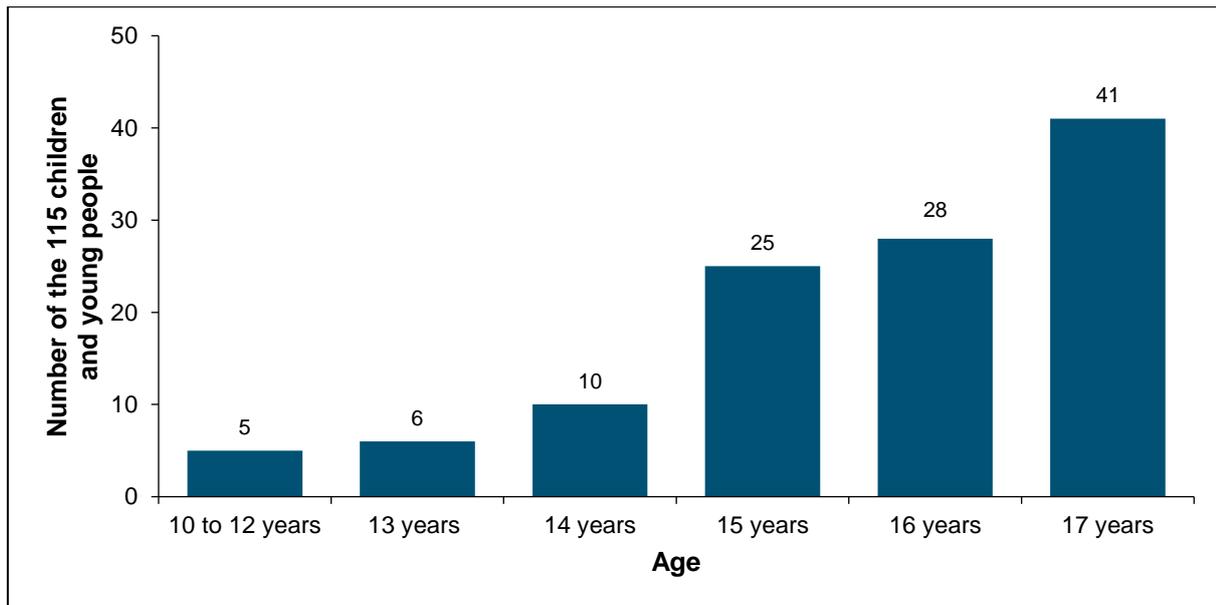
Source: Ombudsman Western Australia

Figure 25 below provides the Western Australian age-specific rates of death by suicide for children between 10 and 13 years of age and young people between 14 and 17 years of age from 2009-10 to 2017-18.

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[301] Ombudsman Western Australia, *Annual Report 2017- 2018*, Ombudsman Western Australia, Perth, September 2018.

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Figure 25: Age-specific rate, for the 115 children and young people
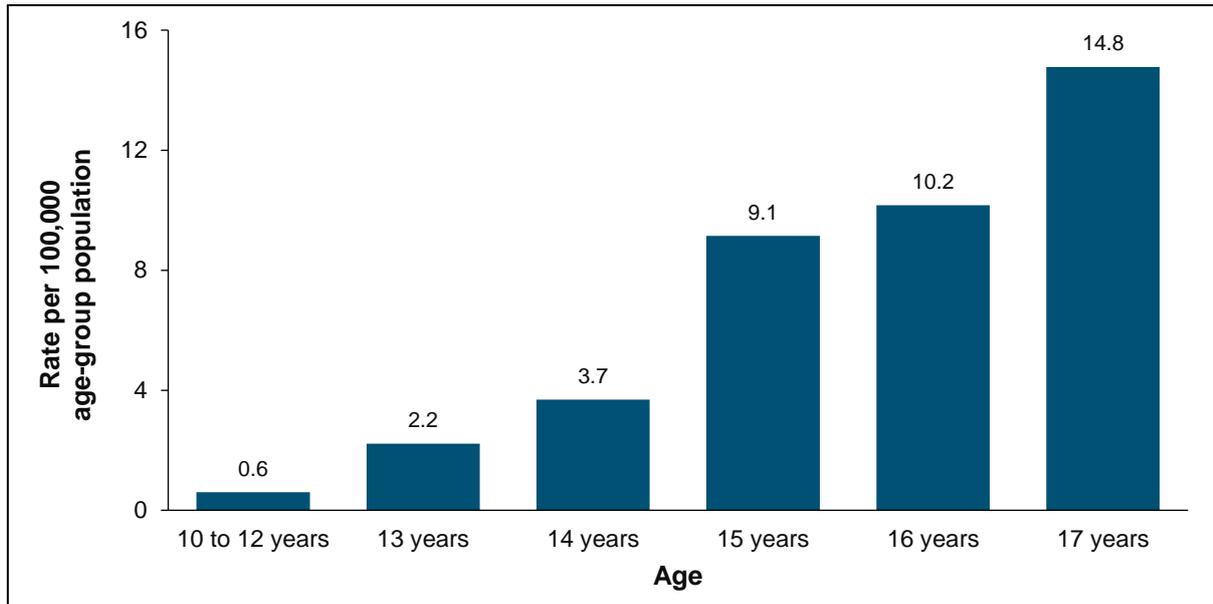
Source: Ombudsman Western Australia

Figure 26 shows that the rate of deaths by suicide in Western Australia has increased across all age-groups except young people aged 14 and 15 years across the 2014 and 2020 Investigations.

Figure 26: Age-specific rate for the 115 children and young people,
by age and Ombudsman Investigation
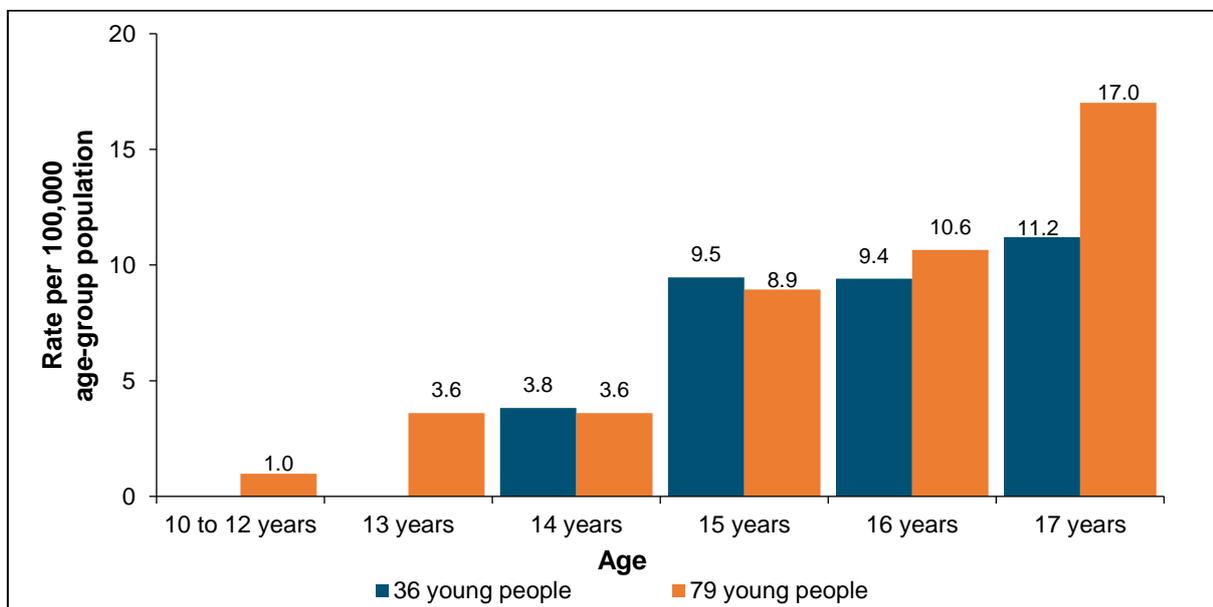
Source: Ombudsman Western Australia

3.5.3 Sex

Age-standardised suicide rates are generally higher for men than for women, as observed by WHO:

> Male:female (M:F) suicide ratios greater than 1 indicate that suicide rates are higher in males than in females. While the M:F ratio is close to 3 in high-

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income countries (i.e. the rates are three times higher in males), the ratio was more equal in low- and middle-income countries. The only countries where the suicide rate was estimated to be higher in females than in males were Bangladesh, China, Lesotho, Morocco, and Myanmar.[302]

Similarly, suicide rates for male children and young people have historically been higher than for female children and young people, however female children young people more frequently report suicidal ideation and attempted suicide.[303]

3.5.3.1   Australia

Nationally, the male to female ratio for deaths by suicide from 2014 to 2018 was 3.15, consistent with global ratios in high income countries.[304] However, the male to female ratio for children and young people between the ages of 5 and 17 years who died by suicide from 2014 to 2018 was more equal, at 1.53. Further, the general trend of higher male suicide rates in Australia was reversed in the 5 to 14 years age group, which had a male to female ratio of 0.86.[305] The ABS recently observed that Australian suicide rates:

> … differ considerably with males consistently accounting for approximately three-quarters of suicide deaths. Of the 3,046 registered suicide deaths, 2,320 were of males and 726 were of females with standardised death rates of 18.6 and 5.7 respectively. …

> The suicide rate for both males and females in 2018 decreased slightly compared to 2017 (0.5 deaths per 100,000 for both sexes), but for both sexes rates have remained comparable over the past five years (2014 to 2018).[306]

In contrast, the age-specific rates of death by suicide for males and females in the 15 to 19 years age group increased by 70 per cent and 85 per cent, respectively, between 2009 and 2018 (with approximately one-third of that change occurring in the five years from 2014 to 2018). Both rates also increased from 2017 to 2018, contrary to the broader population trend (from 13.9 to 17.3 deaths per 100,000 15 to 19 year old male young people, and from 6.9 to 7.2 deaths per 100,000 15 to 19 year old for female young people),[307] as shown in Figure 27.

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[302] World Health Organization, *Suicide in the world: Global Health Estimates*, WHO, Luxembourg, 2019, p 10.

[303] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014,
p 21; Beautrais AL, 'Gender issues in youth suicidal behaviour', *Emergency Medicine*, vol. 14, no. 1, May 2022, pp 35-42.

[304] Mortality Sex Ratios calculated by the office of the Ombudsman using the Australian male and female standardised death rates 2014-18 in Australian Bureau of Statistics, 'Table 11.6 Intentional self-harm, State and territory, Number of deaths, Age-standardised death rate, Rate ratio, Sex, 2008–2017', *Causes of Death, Australia, 2018,* cat. no. 3303.0 ABS, Canberra, September 2019.

[305] Mortality Sex Ratios calculated by the office of the Ombudsman using the 5-17 years, 5-14 years and 15-17 years age-specific death rates 2014-18 in Australian Bureau of Statistics, 'Table 11.10 Intentional self-harm, Number of deaths in children aged 5-17 years by age and sex, Australia, 2014-2018', *Causes of Death, Australia, 2018,* cat. no. 3303.0 ABS, Canberra, September 2019.

[306] Australian Bureau of Statistics, 'Intentional self-harm, key characteristics', *3303.0 – Causes of Death, Australia, 2018*,
Canberra, September 2019, accessed 15 February 2020, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20 Subject/3303.0~2018~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>.

[307] Australian Bureau of Statistics, 'Table 11.2 Intentional self-harm, Age-specific death rates, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018*, cat. no. 3303.0 ABS, Canberra, September 2019.

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Figure 27: Age-specific rate, suicide by young people aged 15 to 19 years, Australia, between 2009 and 2018, by sex
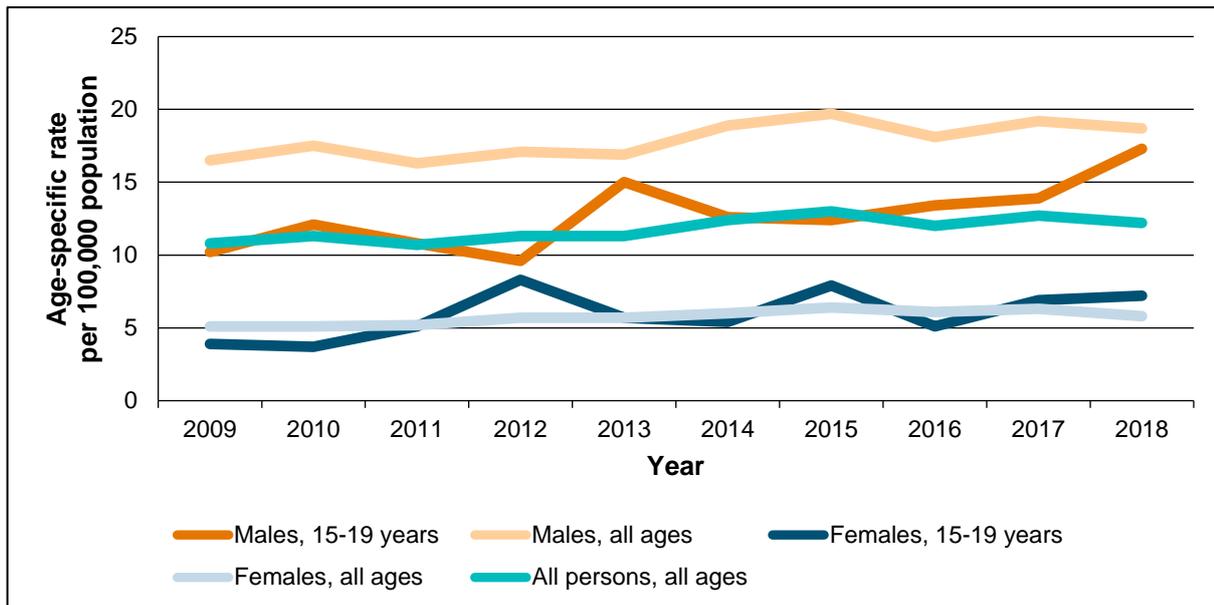
Source: ABS[308]

3.5.3.2   Western Australia

Among the 115 children and young people, there were 43 female children and young people (37 per cent) and 72 male children and young people (63 per cent).

In Western Australia from 1 July 2009 to 30 June 2018, the 9 year age-specific rate of suicide by the 115 children and young people as a proportion of the State's 10 to 17 years population was 5.24 deaths per 100,000. The male to female ratio was 1.60 male deaths by suicide for every female death, consistent with national data demonstrating a consistently lower sex ratio among children and young people, when compared to all deaths by suicide. comprising:

- 6.4 deaths per 100,000 male children and young people; and

- 4.0 deaths per 100,000 female children and young people.[309]

The annual age-specific rate of deaths of children and young by suicide in Western Australia over the 2014 and 2020 Investigation periods has fluctuated from a low of 4.11 deaths per 100,000 in 2013-14 to a maximum of 7.68 in 2016-17.

Figure 28 shows that the annual age-specific rate of deaths by suicide for male and female children young people in Western Australia has followed a similar pattern, from:

- minimums of 2.43 per 100,000 in 2011-12 and of 1.73 per 100,000 male and female children and young people, respectively; and

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[308] Australian Bureau of Statistics, 'Table 11.2 - Intentional self-harm, Age-specific death rates, 5 year age groups by sex, 2009-2018', *Causes of Death, Australia, 2018,* cat. no. 3303.0 ABS, Canberra, September 2019.
[309] Australian Bureau of Statistics, 'Table 55: Estimated Resident Population By Single Year Of Age, Western Australia', *Australian Demographic Statistics, December 2019,* cat. no. 3101.0, ABS, Canberra, December 2019.

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- peaks of 10.28 per 100,000 in 2016-17 and 6.73 per 100,000 for male and female children and young people, respectively.

Figure 28: Annual age-specific rate, suicide by children and young people aged 10 to 17 years, Western Australia, between 2009-10 and 2017-18, by sex
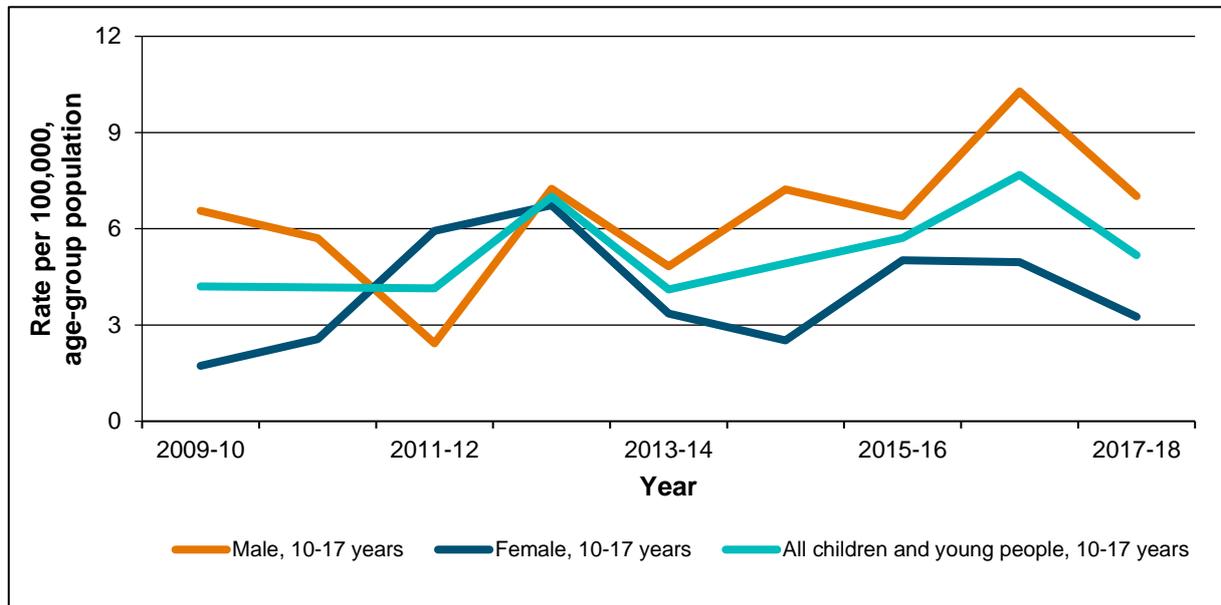
There has been an increase in suicide among 10 to 17 year olds in Western Australia from 1 July 2009 to 30 June 2018, reflected by a 20 per cent increase in the five-year age-specific rate from 4.72 deaths per 100,000 children and young people between 2009-10 to 2014-15, to 5.88 deaths per 100,000 between 2012-13 and 2017-18. The five-year male and female age-specific rates also increased by 26 per cent and 10 per cent, respectively.

In the two most recent five-year periods, suicide by:

- male children and young people increased 26 per cent (from 5.35 deaths per 100,000 between 2009-10 and 2014-15, to 7.19 deaths per 100,000 between 2012-13 and 2017-18); and

- female children and young people increased by 10 per cent (from 4.06 deaths per 100,000 between 2009-10 and 2014-15 to 4.52 deaths per 100,000 between 2012-13 and 2017-18).

3.5.4 Age and Sex

The Office's analysis of the age and sex of the children and young people who died by suicide as shown in Figure 29, identifies that:

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[310] Australian Bureau of Statistics, 'Table 11.7 Intentional self-harm by State and territory of usual residence and Sex, Age-standardised death rates, 2009-2018', *Causes of Death, Australia, 2018,* cat. no. 3303.0 ABS, Canberra, September 2019; Australian Bureau of Statistics, 'Table 55: Estimated Resident Population By Single Year Of Age, Western Australia', *Australian Demographic Statistics, December 2019*, cat. No. 3101.0, ABS, Canberra, June 2020.

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- male young people were over-represented within the 17 year old age group (80 per cent); and

- female children were over-represented within the 10 to 13 year old age group (64 per cent).

Figure 29: Age at time of death, by sex,
for the 115 children and young people
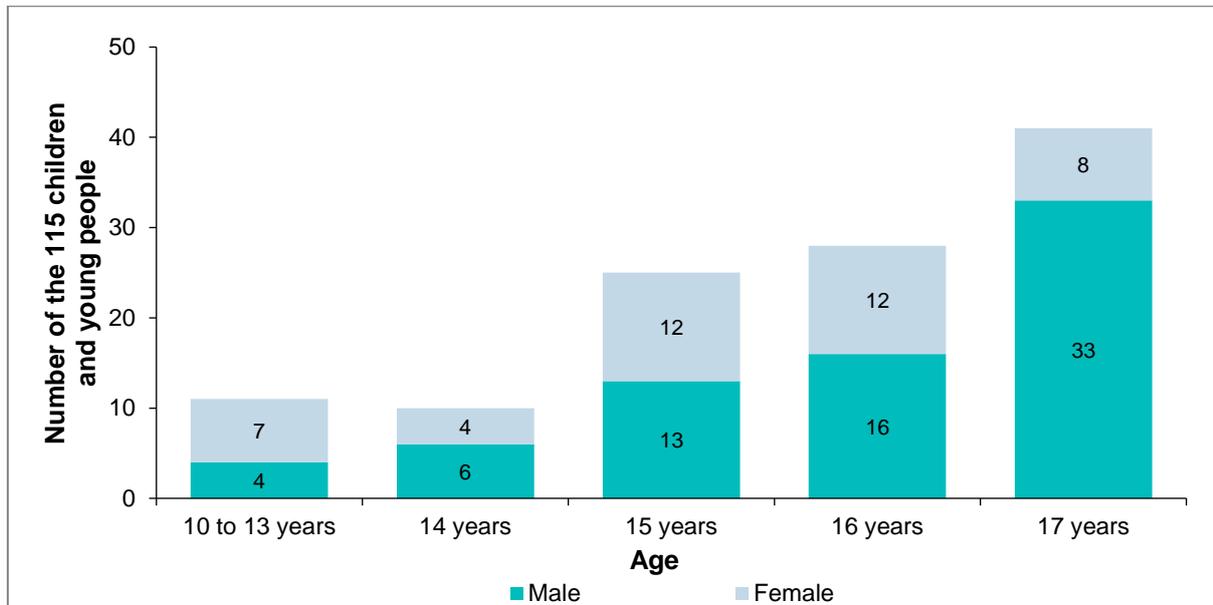
Source: Ombudsman Western Australia

3.5.5 Remoteness and region of residence

The ABS reports that from 2014 to 2018:

- across Australia, 59 per cent of people of all ages who died by suicide resided outside of greater capital city areas,[311] compared to 33 per cent of the population;[312]

- the proportion of Australian children and young people between the ages of 5 and 17 in capital cities and other areas of their home state or territory, was almost equal (49 per cent resided in a capital city);[313]

- children and young people aged 5 to 17 years residing outside capital cities died by suicide at a higher rate across Australia, and in every Australian state and territory where comparison capital city data is available. (Figure 30).[314]

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[311] Australian Bureau of Statistics, 'Table 11.13 Intentional self-harm, Age specific death rates, 10 year age groups by sex, 2007-2016', *Causes of Death, Australia, 2016,* cat. no. *3303.0,* ABS, Canberra, September 2017.
[312] Australian Bureau of Statistics, *Regional Population Growth, Australia, 2016-17*, ABS, Table 1, cat. no. 3218.0, ABS, Canberra, August 2018.
[313] Australian Bureau of Statistics, 'Table 11.13 Intentional self-harm, Age specific death rates, 10 year age groups by sex, 2007-2016', *Causes of Death, Australia, 2016,* cat. no. *3303.0,* ABS, Canberra, September 2017.
[314] Australian Bureau of Statistics, 'Table 11.13 Intentional self-harm, Age specific death rates, 10 year age groups by sex, 2007-2016', *Causes of Death, Australia, 2016,* cat. no. *3303.0,* ABS, Canberra, September 2017.

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Figure 30: Five year age-specific rate, suicide by children and young people aged 5 to 17 years, by state, territory and region of usual residence, 2014 to 2018
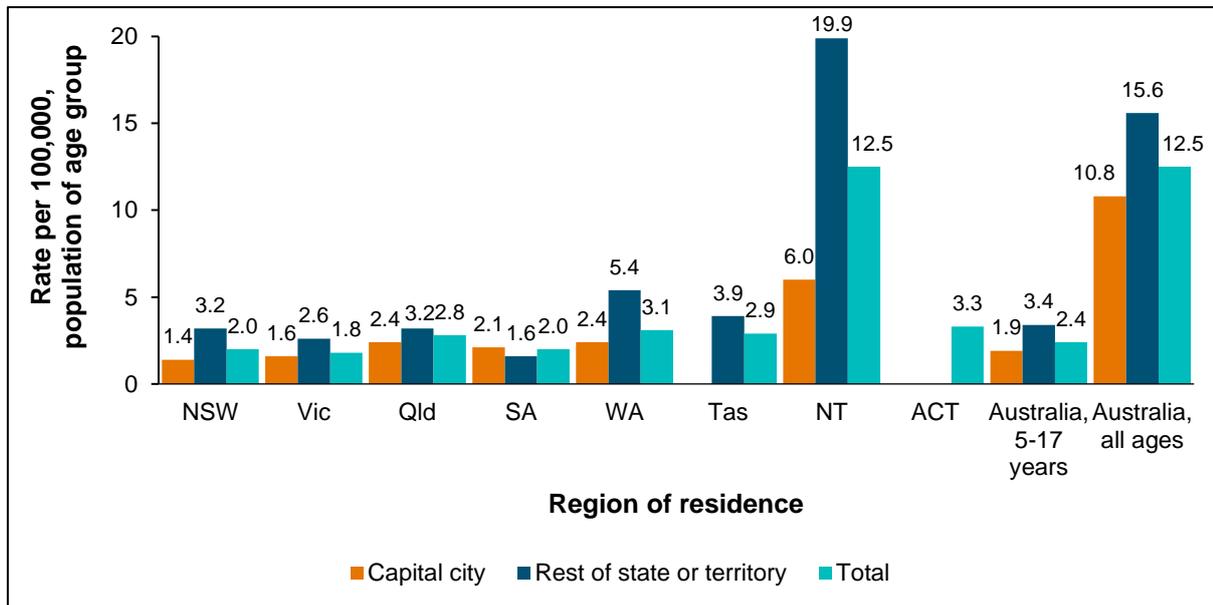
Source: ABS[315]

As shown in Figure 31, below, the majority of the 115 children and young people (57 per cent) were residing in the Perth metropolitan area at the time of their death.[316]

Forty-nine of the 115 children and young people (43 per cent) resided in a remote or regional area[317] at the time of their death, as follows:

• 22 children and young people (19 per cent) were residing in a regional area;

• 8 children and young people (7 per cent) were residing in a remote area; and

• 19 children and young people (17 per cent) were residing in a very remote area, all of whom were Aboriginal or Torres Strait Islander.

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[315] Australian Bureau of Statistics, 'Table 11.13 Intentional self-harm, Age specific death rates, 10 year age groups by sex, 2007-2016', *Causes of Death, Australia, 2016,* cat. no. *3303.0,* ABS, Canberra, September 2017.
[316] Using regions as defined in Schedule 4 of the *Planning and Development Act 2005,* viewed 15 March 2019, <https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_722_homepage.html>.
[317] Australian Bureau of Statistics, *Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure,* cat. no. 1270.0.55.005, ABS, Canberra, July 2011.

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Figure 31: Remoteness of usual residence at time of death,
for the 115 children and young people
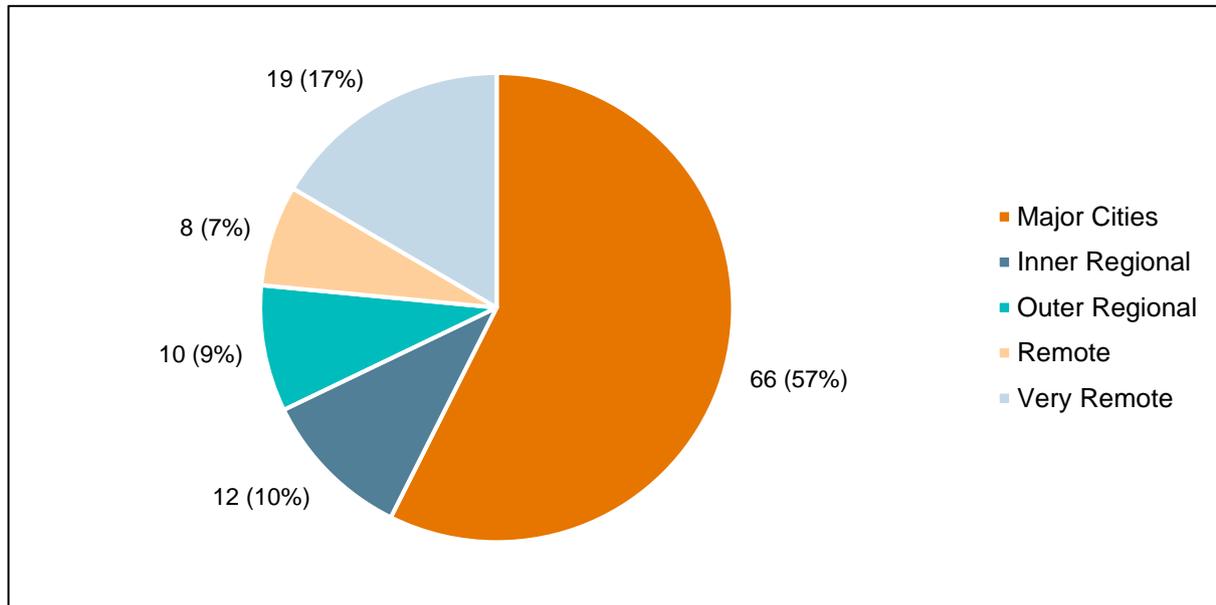
Source: Ombudsman Western Australia

In the 2014 Investigation, young people residing in outer regional and very remote areas were over-represented as compared to the estimated all ages population. During the 2020 Investigation, children and young people in all regional and remote areas of the State were over-represented, taking into account the resident population of all ages residing in each of these areas.[318] (Figure 32)

Figure 32: Remoteness of residence at time of death, for the 115
children and young people, by Ombudsman Investigation
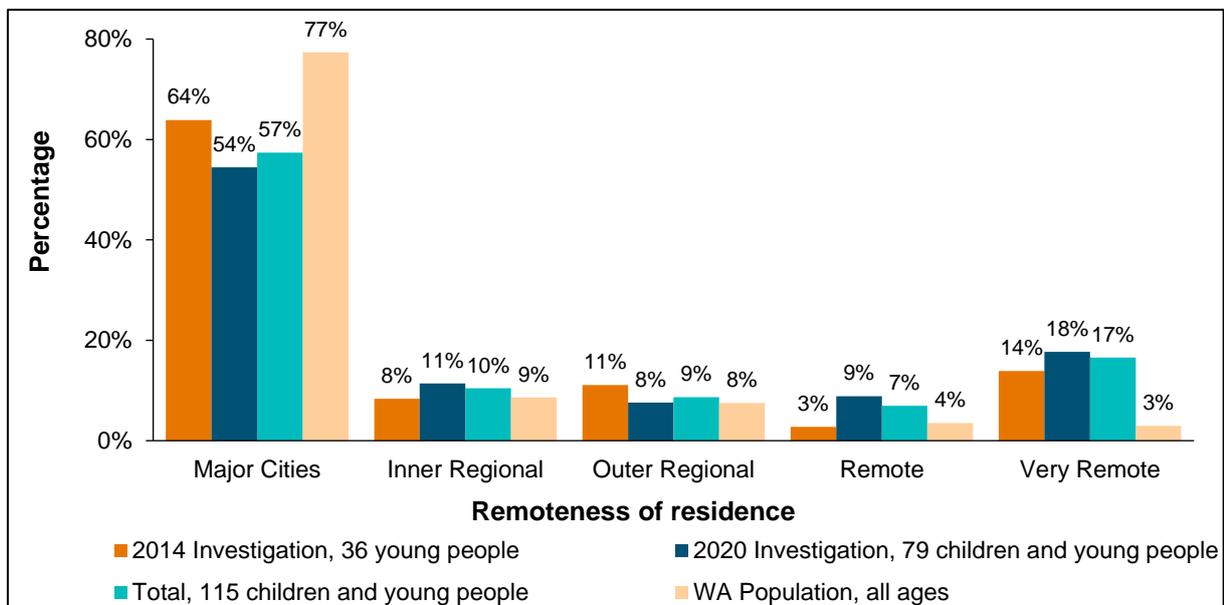
Source: Ombudsman Western Australia; ABS[319]

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[318] Australian Bureau of Statistics, *Regional Population Growth, Australia, 2016-17*, ABS, Table 1, cat. no. 3218.0, ABS, Canberra, August 2018.
[319] Australian Bureau of Statistics, *Regional Population Growth, Australia, 2016-17*, ABS, Table 1, cat. no. 3218.0, ABS, Canberra, August 2018.

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3.5.6 Place of residence

The Office's geographic analysis of the 115 children and young people identified that the majority were residing in the Greater Perth area at the time of their death (53 per cent).[320] However, the Greater Perth area was under-represented among the 115 children and young people compared to its resident 10 to 19 years old population, as a proportion of Western Australia's total population.

Figure 33, below, shows that some regions of Western Australia were over-represented when compared to the distribution of the population aged between 10 to 19 years. The Kimberley region is home to 1 per cent of Western Australia's 10 to 19 years old residents, however 17 per cent of the 115 children and young people resided there at the time of their death. Similarly, the Gascoyne, Goldfields Esperance, Mid West and South West regions were also over-represented among the 115 children and young people.

Figure 33: Region of residence for the
115 children and young people, by population
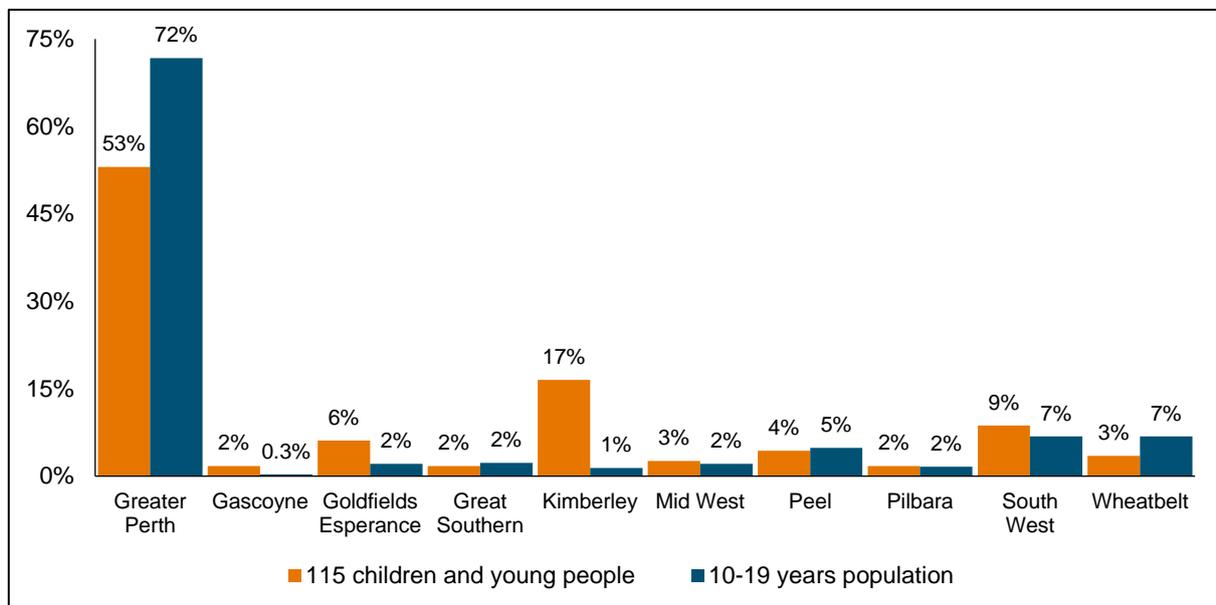
Source: Ombudsman Western Australia; Department of Primary Industries and Regional Development (WA), ABS[321]

3.5.7 Aboriginality

In Australia, Aboriginal and Torres Strait Islander children and young people die by suicide at a rate of around five times more that non-Aboriginal children and young people. However, it is important to note that Aboriginality, of itself, does not cause an increased risk of suicide in children and young people. Rather:

> High rates of suicide among Aboriginal and Torres Strait Islander peoples are commonly attributed to a complex set of factors which not only includes

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[320] Using regions as defined in Schedule 4 of the *Planning and Development Act 2005* (WA).
[321] Some regions have been combined to ensure information contained in this report is sufficiently de-identified. Population data for regions sourced from Department of Primary Industries and Regional Development, 'Our WA Regions', 2017, viewed 6 September 2018, <www.drd.wa.gov.au/regions/Pages/default.aspx>. Population data for Perth metropolitan area derived using Estimated Resident Population for all persons in Western Australia in June 2013, from Australian Bureau of Statistics, 'Table 4: Estimated Resident Population, States and Territories', *Australian Demographic Statistics, June 2018*, cat. no. 3101.0, ABS, Canberra, December 2018.

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disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic determinations that impact on Aboriginal social and emotional wellbeing and mental health.[322]

Figure 34: Age-specific rate, children and young people aged 5 to 17 deaths by suicide, 2014 to 2018, by Aboriginality and state or territory of usual residence
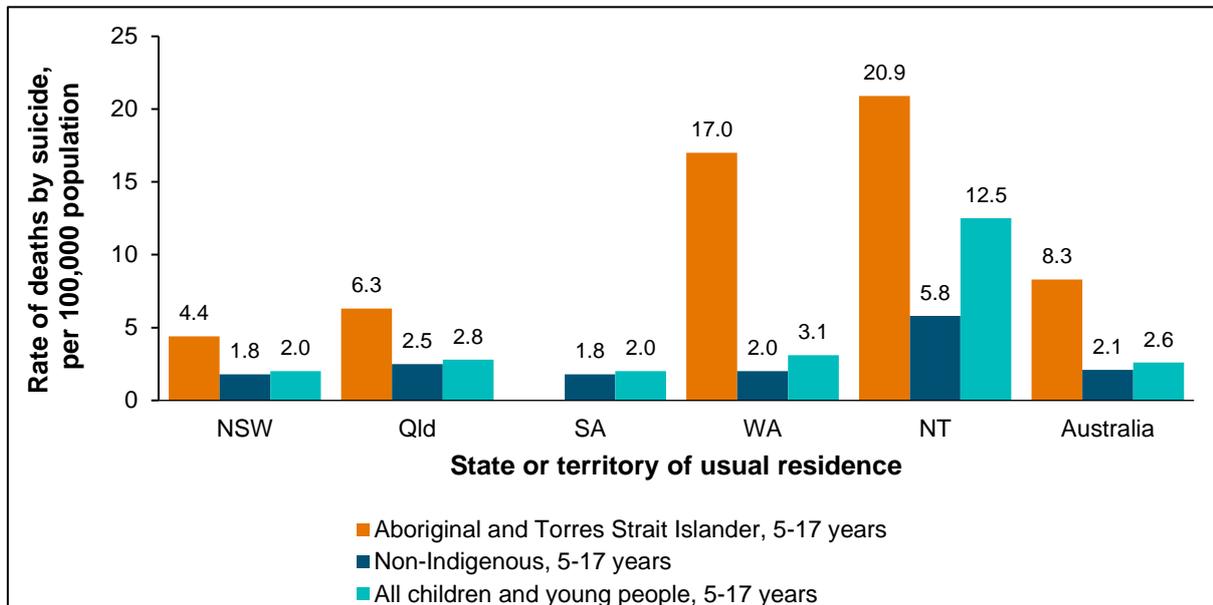
Source: ABS[323]

In Western Australia for the years 2014-2018, Aboriginal children and young people died by suicide at a rate eight times higher than that of non-Aboriginal children and young people.[324]

Aboriginal and Torres Strait Islander children and young people are similarly significantly over-represented among the 115 children and young people. Records obtained during the 2020 investigation indicate that 43 of the 115 children and young people (37 per cent) identified as Aboriginal or Torres Strait Islander, and 72 (63 per cent) identified as non-Aboriginal. For comparison, 7 per cent of children and young people 0 to 17 years in Western Australian are Aboriginal or Torres Strait Islander.[325]

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[322] Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, May 2018, Australian Government, Canberra, May 2013, viewed 3 May 2019, <https://www.health.gov.au/internet/main/publishing.nsf/content/1CE7187EC4965005CA25802800127B49/$File/Indigenous%20Strategy.pdf>, p. 13.

[323] Australian Bureau of Statistics, 'Table 11.12 – Intentional self-harm, Number of deaths in children aged 5-17 years by Aboriginal and Torres Strait Islander status, NSW, Qld, SA, WA and NT, 2013-2017', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018.

[324] Australian Bureau of Statistics, 'Table 11.12 – Intentional self-harm, Number of deaths in children aged 5-17 years by Aboriginal and Torres Strait Islander status, NSW, Qld, SA, WA and NT, 2013-2017', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018.

[325] Population distribution for children and young who identify as Aboriginal and aged between 5 and 19 years obtained from: Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2016', *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.

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3.5.7.1   Age

Among the 115 children and young people, Aboriginal children and young people died by suicide at a younger age than non-Aboriginal children and young people (Figure 35). This age difference is most pronounced among female children and young people, with the median age for female Aboriginal and Torres Strait Islander children and young people being 15 years, whilst for non-Aboriginal and Torres Strait Islander female children and young people, it is 16 years.

Figure 35: Age at time of death for the 115 children and young people, by Aboriginal status
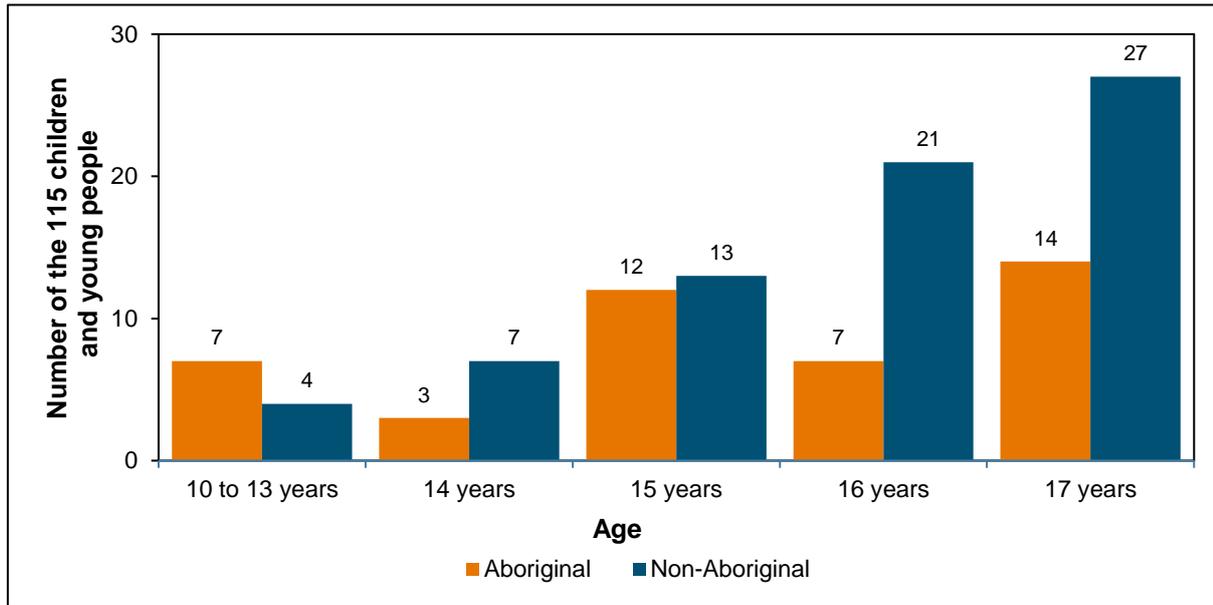
Source: Ombudsman Western Australia

3.5.7.2   Sex

Unlike non-Aboriginal children and young people who died by suicide, male and female Aboriginal and Torres Strait Islander children and young people died by suicide at approximately equal prevalence. Twenty-two were male (51 per cent) and 21 were female (49 per cent). By comparison, among the 72 non-Aboriginal and/or Torres Strait Islander children and young people who died by suicide, 50 were male (69 per cent) and 22 were female (31 per cent), as shown in Figure 36:

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Figure 36: Aboriginality of the 115 children and young people, by sex
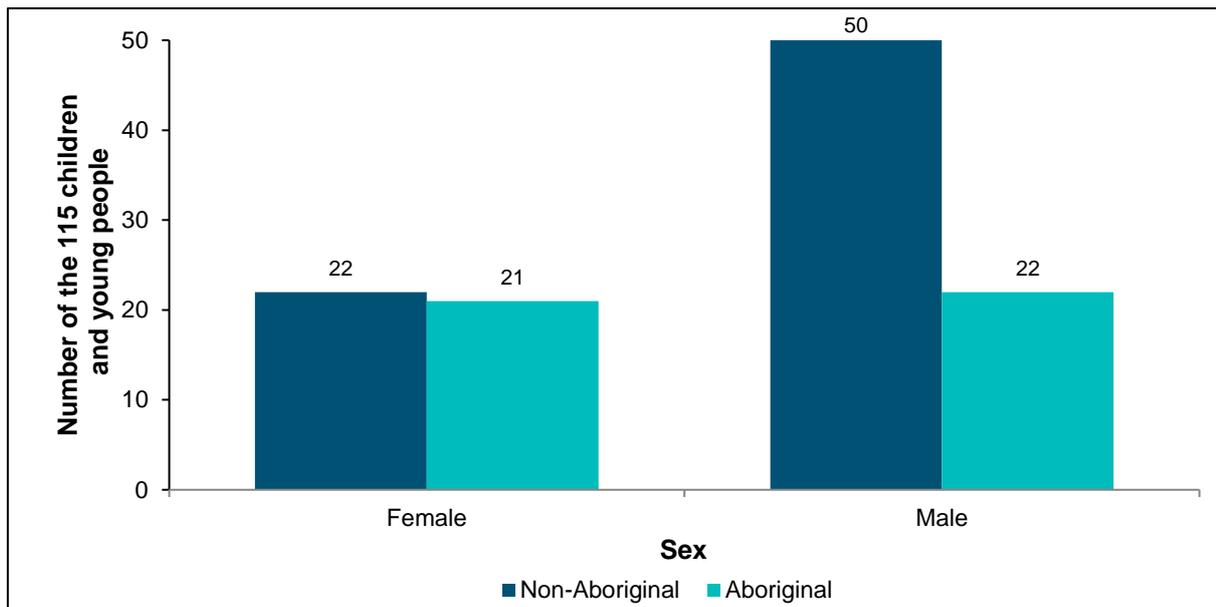
Source: Ombudsman Western Australia

3.5.7.3   Region of residence

Almost half of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide resided in a very remote area at the time of their death. Using regions defined by the ABS, 19 children and young people (44 per cent) were residing in a very remote area, seven young people (16 per cent) were residing in a remote area, six young people (14 per cent) were residing in a regional area, and 11 (26 per cent) resided in major cities.

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Figure 37: Remoteness of residence, for the 43 Aboriginal children and young people
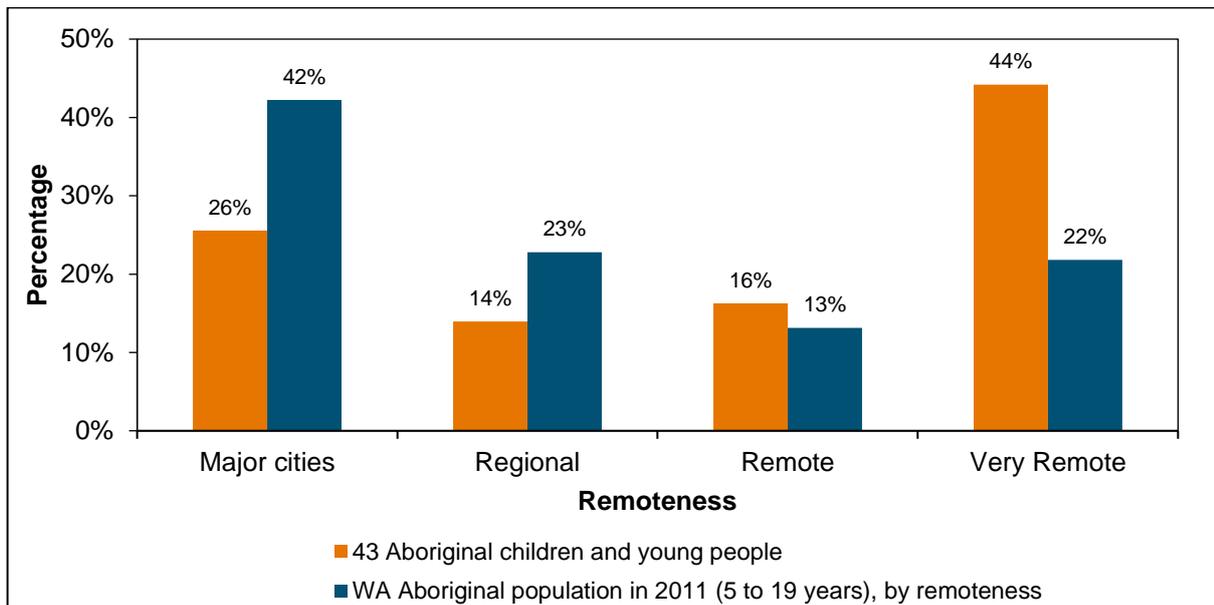
Of the 11 Aboriginal and Torres Strait Islander children and young people who resided in a major city, 10 (91 per cent) were female. In contrast, 21 of the 32 Aboriginal and Torres Strait Islander children and young people (66 per cent) who resided in a regional, remote or very remote area at the time of their death were male.

3.5.8 Homelessness

The research literature identifies that homeless young people are more vulnerable to mental ill-health, self-harm and suicidal ideation.[327] 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.[328] They may become homeless as a result of other risk factors for suicide, including abuse, neglect, family and domestic violence or family disunity.[329] According to *The Cost of Youth Homelessness in Australia* study, homeless young people have much higher levels of psychological distress and reported self-harming and suicidal behaviours than young people in the general population.[330]

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[326] Population distribution for children and young who identify as Aboriginal and aged between 5 and 19 years obtained from: Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2016', *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.

[327] headspace, National Youth Mental Health Foundation, *Position Paper – homelessness*, 21 June 2011, viewed 18 March 2019, <https://headspace.org.au/assets/Uploads/Corporate/Homelessness-Position-Paper.pdf>, p. 2.

[328] Bailey SL, Camlin CS and Ennett ST, 'Substance use and risky sexual behavior among homeless and runaway youth', *Journal of Adolescent Health*, vol. 23, no. 6, December 1998, pp. 378-388.

[329] Hunter C, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, January 2014, viewed 18 March 2019, <https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents>.

[330] Fildes J, Perrens B and Plummer J, *Young people's experiences of homelessness: Findings from the Youth Survey 2017*, Mission Australia 2018, viewed 2 May 2019, <https://www.missionaustralia.com.au/publications/youth-survey/780-young-people-s-experience-of-homelessness-findings-from-the-youth-survey-2017/file>.

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A note on the Office's work in relation to experiences of homelessness

The Office is currently undertaking a major own motion investigation into homelessness.

The ABS 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.

Applying these definitions, 31 (27 per cent) of the 115 children and young people were recorded as having experienced at least one form of homelessness during their lives. All 31 of the children and young people recorded as experiencing homelessness were in Group 1.

For comparison, the ABS estimates that in 2016, 0.4 per cent of children under 12 and 0.5 per cent of 12 to 18-year-olds were experiencing primary or secondary homeless in Australia.[331] The ABS also highlights that:

> Although youth are over-represented in the homeless population, homeless estimates for youth are likely to have been underestimated in the Census due to a usual address being reported for some homeless youth.
>
> For some youth (sometimes referred to as 12–18 years or 12–24 years) who are homeless and 'couch surfing', a usual residence may still be reported in the Census. Their homelessness is masked because their characteristics look no different to other youth who are not homeless but are simply visiting on Census night.
>
> ABS has not yet been able to establish any reliable way, with existing data sources, of estimating homelessness among youth staying with other households and for whom a usual address is reported in the Census. Service providers and researchers have indicated that the estimates of homeless youth derivable from Census data do not concord with their knowledge about youth homelessness.[332]

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[331] Australian Bureau of Statistics, *Census of Population and Housing: Estimating homelessness, 2016, Youth Homelessness*, cat. no 2049.0, ABS, Canberra, March 2018; Estimated resident population in Australia obtained from: Australian Bureau of Statistics,' Table 59: Estimated resident population by single year of age, Australia', *Australian Demographic Statistics*, cat. no. 3101.0, ABS, Canberra, June 2018.
[332] Australian Bureau of Statistics, Census of Population and Housing: Estimating homelessness, 2016, Youth Homelessness, cat. no 2049.0, ABS, Canberra, March 2018.

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3.5.9   Socio-economic status

According to the World Health Organization, the socio-economic 'conditions in which people are born, grow, live, work and age … determine their risk of [avoidable] illness'[333] and death:

> The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that in general the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle and high income countries. The social gradient in health means that health inequities affect everyone.[334]

The research literature identifies that children and young people in families with low socio-economic status have a higher rate of suicide than children and young people who grow up in families with higher socio-economic status.[335] This is due to the:

> … strong relationship between area-level indicators of socioeconomic status and mortality (social gradient of health). Those in areas with fewer economic resources have higher rates of illness, behavioural risk factors and poorer access to health services.[336]

In Australia, data on socio-economic groups is collected by the ABS and published as the Socio-Economic Indexes for Areas (**SEIFA**) Index of Relative Socio-economic Disadvantage (**IRD**):

> A **low** score indicates relatively greater disadvantage in general. For example, an area could have a low score if there are:
>
> - many households with low income,
>
> - many people with no qualifications, or
>
> - many people in low skill occupations.
>
> A **high** score indicates a relative lack of disadvantage in general. For example, an area may have a high score if there are:
>
> - few households with low incomes,
>
> - few people with no qualifications, or
>
> - few people in low skilled occupations.[337]

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[333] World Health Organization, Social determinants of health: Key concepts, viewed 3 May 2019, <https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/>.
[334] World Health Organization, *Social determinants of health: Key concepts*, viewed 3 May 2019, <https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/>.
[335] Queensland Family and Child Commission, *Annual Report: Deaths of children and young people, Queensland, 2017-18*, Queensland Government, Brisbane, 2018; Australian Institute of Health and Welfare, *Injury among young Australians*: *Bulletin 60*, May 2008, viewed 18 March 2019, <https://www.aihw.gov.au/getmedia/d0387be9-76fc-4e2c-8afa-cdb1c4aa2591/bulletin60.pdf.aspx?inline=true>, p. 27.
[336] New South Wales Ombudsman Child Death Review Team and the Australian Institute of Health and Welfare, Spatial analysis of child deaths in New South Wales: A report under section 34H Community Services (Complaints, Reviews and Monitoring) Act 1993, New South Wales Ombudsman, Sydney, April 2018, p. 40.
[337] Australian Bureau of Statistics, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016, cat. no. 2033.0.55.001, ABS, Canberra, March 2018.

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Death by suicide is both more likely for children and young people living in the postal area codes with a greater degree of socio-economic disadvantage, indicated by lower SEIFA scores. Children and young people living in the bottom 40 per cent of post codes, when ranked by State-based relative disadvantage scores are over-represented among the 115 children and young people who died by suicide accounting for 50 per cent of deaths. Sadly, suicide by children and young people is most prevalent amongst the most disadvantaged post code areas of residence (Figure 38).[338]

Figure 38: Relative socio-economic disadvantage of the 115 children and young people who died by suicide, by investigation period[339]
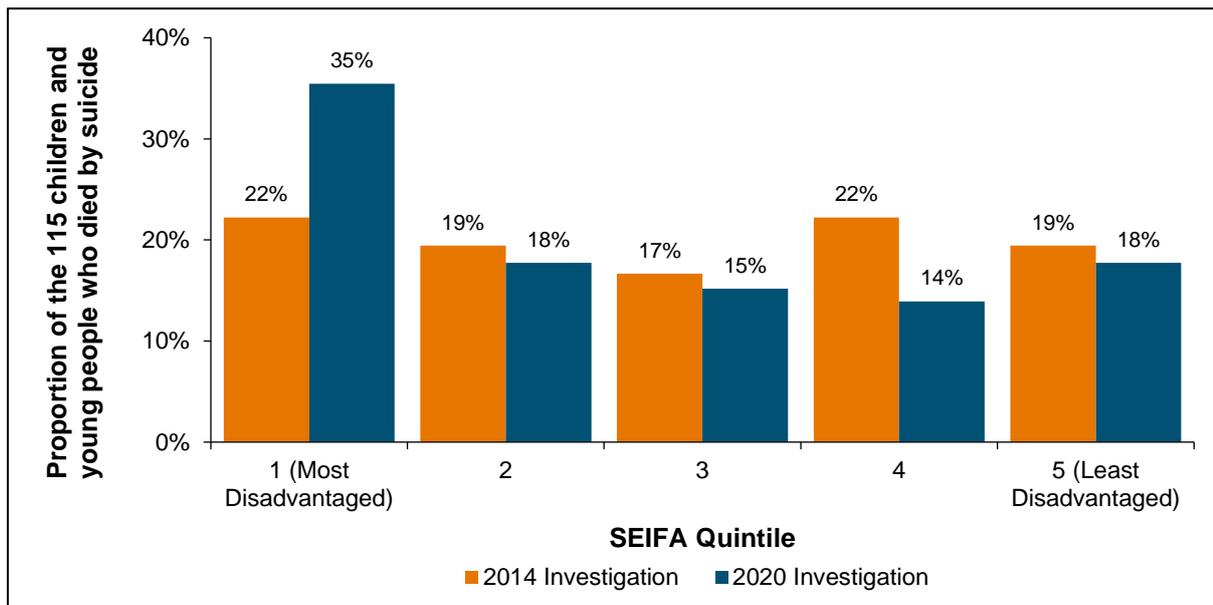
Source: Ombudsman Western Australia; ABS[340]

3.5.10 Gender identity and sexual orientation

Individuals with diverse gender identity and sexual orientation 'are thought to have an elevated risk of suicide'.[341] However, as noted by the National Children's Commissioner, 'sexual orientation, gender identity and/or intersex status do not elevate risk per se, but rather ongoing negative experiences and discrimination can increase the risks.'[342]

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[338] Australian Bureau of Statistics, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016, cat. no. 2033.0.55.001, ABS, Canberra, March 2018.

[339] SEIFA (Socio-Economic Indexes for Areas) is a measure that ranks geographic areas in terms of their socio-economic characteristics. The Office assigned scores from the ABS 2016 Index of Relative Disadvantage (IRD) SEIFA to each death, based on the child or young person's residential postcode at the time of their death. Quintiles were also assigned based upon the State-based decile ranks also published by the ABS. SEIFA IRD scores lower than 1000 indicate more disadvantaged areas of residence and do not convey any information about the individual socioeconomic status of a child, young person or their family.

[340] Australian Bureau of Statistics, 'Table 2: Postal Area (POA) Index of Relative Socio-economic Disadvantage', *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016*, cat. no. 2033.0.55.001, ABS, Canberra, March 2018.

[341] Haas AP and Lane A, 'Collecting sexual orientation and gender identity data in suicide and other violent deaths: a step towards identifying and addressing LGBT mortality disparities', *LGBT Health*, vol. 2, no. 1, March 2015, pp. 84-87, doi: 10.1089/lgbt.2014.0083.

[342] Australian Human Rights Commission, *Children's Rights Report 2014*, AHRC, Sydney, 2014, p. 109.

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The research literature observes that little data about the prevalence of suicidal and self-harming behaviour by children and young people with diverse gender and/or sexual orientation is available for analysis.[343]

Among the 115 children and young people, records indicate that six young people 15 to 17 years were recorded as having diverse sexual orientation and/or gender identity.

The Office notes that this number may not capture all of the children and young people who died by suicide with diverse gender identity and sexual orientation as:

- some children and young people may not have disclosed their gender identity or sexual orientation to State government departments and authorities; and

- the recording practices and policies of State government departments and authorities regarding the capture of gender identity and sexual orientation data vary.

The Office notes the research literature indicating that this lack of information about deaths of gender and/or sexuality diverse children and young people 'hinders understanding of the prevalence and patterns of suicide … and the development of targeted interventions and prevention programs'.[344] However, this is not to say that all State government agencies and authorities should collect this information. The collection of gender identity and sexual orientation information and the privacy of the individual must be balanced carefully and the individual's decision to disclose information (or not to disclose this information) deeply respected.

3.5.10.1   Gender identity

Gender identity is '[a] person's deeply felt sense of being a man, a woman, both, in between, neither or something other. It is recognised that's a person's sex as registered at their birth may not necessarily be the same as the person's gender identity'.[345]

Transgender young people are people for whom '… gender identity differs from… biological sex assigned at birth'.[346] The prevalence of transgender people has been estimated to be about 0.5 to 1.3 per cent of the population.[347]

Recent research literature identifies increasing healthcare presentations associated with diverse gender identity in children and adolescents, particularly for girls and young women, reversing an historic overrepresentation of boys and young men.[348]

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[343] Australian Human Rights Commission, *Children's Rights Report 2014*, AHRC, Sydney, 2014, p. 109.

[344] Haas AP and Lane A, 'Collecting sexual orientation and gender identity data in suicide and other violent deaths: a step towards identifying and addressing LGBT mortality disparities', *LGBT Health*, vol. 2, no. 1, March 2015, pp. 84-87,
doi: 10.1089/lgbt.2014.0083.

[345] Law Reform Commission of Western Australia, Final Report: Review of Western Australian legislation in relation to the registration or change of a person's sex and/or gender and status relating to sex characteristics, Perth, November 2018, p. 12.

[346] Health Promotion Unit, University of Western Australia, *Sexuality and gender terms*, viewed 18 March 2019, <http://www.student.uwa.edu.au/experience/health/fit/share/sexuality/definitions>.

[347] Zucker KJ, 'Epidemiology of gender dysphoria and transgender identity', *Sexual Health*, vol. 14, no. (5), October 2017, pp. 404-411; Crissman HP et al, 'Transgender demographics: a household probability sample of US adults', *APJH Public Health*, vol. 107, no. 2, February 2017, pp. 213-215.

[348] Kaltiala-Heino R et al, 'Gender dysphoria in adolescence: current perspectives', *Adolescent Health, Medicine and Therapeutics*, vol. 9, March 2018, pp. 31-41, doi: 10.2147/AHMT.S135432; Zucker KJ, 'Epidemiology of gender dysphoria and transgender identity', *Sexual Health*, vol. 14, no. (5), October 2017, pp. 404-411.

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A recent Western Australian study of 859 trans and gender diverse young people, of which 74 per cent were girls and young women and 26 per cent were boys and young men, by the Telethon Kids Institute found higher rates of risk factors associated with suicide, and that:

- almost 50 per cent of these young people had previously attempted suicide; and

- about 80 per cent of these young people had self-harmed.[349]

3.5.10.2   Intersex children and young people

Intersex children and young people are 'born with reproductive organs, genitalia and/or sex chromosomes that are not exclusively male nor female.'[350] The research literature identifies that between 0.05 and 1.7 per cent of the population are born with intersex traits and reports a higher risk of suicide for intersex people.[351] In a study of 176 intersex people in Australia, 42 per cent had experienced self-harm ideation, 26 per cent had previously engaged in self-harming behaviour, 60 per cent had experienced suicidal ideation and 19 per cent had attempted suicide.[352]

3.5.10.3   Sexual orientation

The Canberra Lesbian Gay Bisexual Transgender Intersex Queer/Questioning Community Consortium defines sexual orientation as:

> A person's sexual identity, behaviour, and attraction all contribute to determining their sexual orientation. Sexual identity refers to the way a person might label themselves, their behaviour refers to the kinds of sexual acts in which they engage, and their attraction refers to the kinds of people to whom they are sexually attracted.[353]

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[349] Strauss P et al, 'Summary of results', *Trans Pathways: the mental health experiences and care pathways of trans young people*, Telethon Kids Institute, Perth, 2017, p. 33.

[350] Health Promotion Unit, University of Western Australia, *Sexuality and gender terms*, viewed 18 March 2019, <http://www.student.uwa.edu.au/experience/health/fit/share/sexuality/definitions>.

[351] United Nations for LGBT Equality, *Fact Sheet: Intersex*, viewed 18 March 2019, <https://www.unfe.org/wp-content/uploads/2017/05/UNFE-Intersex.pdf>.

[352] Jones T et al, *Intersex: Stories and Statistics from Australia*, OpenBook Publishers, Cambridge, 2016, doi: 10.11647/OBP.0089, p. 121.

[353] Barclay A and Russell M, *A guide to LGBTIQ-inclusive data collection*, Canberra LGBTIQ Community Consortium, Canberra, 2017, viewed 18 March 2019, <https://aidsaction.org.au/images/resource-library/LGBTIQ%20Inclusive%20Data%20Collection%20-%20a%20Guide.pdf>, p. 4.

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Young people who identify as same-sex attracted are 'emotionally, mentally and physically attracted to' people of the same sex as themselves.[354] Approximately five to 11 per cent of Australians may identify as same-sex attracted.[355]

The research literature identifies bisexual or same-sex attracted sexual identity as a risk factor for suicide.[356] A recent review of the literature, which considered both community and population surveys, identified that same-sex attracted adults were between 2.8 and 5 times more likely to attempt suicide compared to heterosexual adults.[357] A study of private households in the United Kingdom found that approximately 14 per cent of lifetime suicide attempts were by individuals who identified as non-heterosexual.[358]

However, many people who are same-sex attracted who attempt suicide have not disclosed their sexual orientation to others, or to only very few people. A 2006 study of suicide attempt prevalence amongst same-sex attracted youth found that attempts were made, on average, 0.78 years before any other person was aware of their sexual orientation.[359]

There is a scarcity of research literature relating to suicide by bisexual or same-sex attracted Aboriginal and/or Torres Strait Islander young people. However, the research literature highlights that:

> … the multiple layers of risk factors impacting on sexuality diverse, transgender, gender diverse and intersex children and young people and how these intersectionalities may, in turn, influence patterns of … self-harm and suicidal behaviour. For example, risk factors can be compounded for children and young people who also identify as Aboriginal or Torres Strait Islander, are from culturally or linguistically diverse backgrounds, or who have a disability.
>
> Intra-family homophobia and transphobia is also a serious risk factor. Family rejection often increases the isolation and despair for children and young people who are sexuality diverse, transgender, gender diverse and intersex. Supportive family relationships have been found to be protective factors

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[354] Health Promotion Unit, University of Western Australia, *Sexuality and gender terms*, viewed 18 March 2019, <http://www.student.uwa.edu.au/experience/health/fit/share/sexuality/definitions>.
[355] Quinn K, 'Rural suicide and same-sex attracted youth: issues, interventions and implications for rural counsellors', *Rural and Remote Health*, 2003, vol. 3, no. 222, November 2003, viewed 18 March 2019, <https://www.rrh.org.au/journal/download/pdf/222/>.
[356] Paul JP et al, 'Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents', *American Journal of Public Health*, vol. 92, no. 8, August 2002, pp. 1338-1345.
[357] Hottes TS et al, 'Lifetime prevalence of suicide attempts among sexual minority adults by study sampling strategies: a systematic review and meta-analysis', *American Journal of Public Health*, vol. 106, no. 5, May 2016, e1-12,
doi: 10.2105/AJPH.2016.303088.
[358] Chakraborty A et al, 'Mental health of the non-heterosexual population of England', *British Journal of Psychiatry*, vol. 198, no. 2, February 2011, pp. 143-148.
[359] Nicholas J and Howard J, 'Better dead than gay? Depression, suicide ideation and attempt among a sample of gay and straight-identified males aged 18 to 24', *Youth Studies Australia*, vol. 17, no. (4), pp. 28-33.

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against … self-harm and suicidal behaviour in children and young people.[360]

Suicide risk may also be higher for children and young people with diverse sexual orientation who reside in rural and remote areas.[361]

3.5.11 Social media and bullying

As highlighted in the 2014 Investigation, social media and bullying have been identified in the research literature as 'potential or emerging' risk factors associated with suicide by young people, who:

> … often express suicidal thoughts on social media before talking face-to-face to friends, family members, or healthcare professionals about their mental health issues. They are always connected through the Internet and social media. Social media has become a powerful monitoring tool for suicide among youth especially when data mining technology, artificial intelligence, and machine learning algorithms are applied.[362]

Further research undertaken during the 2020 Investigation identified five major themes relating to social media and suicide by children and young people, both negative and positive, namely that:

- analysis of social media posting frequency and language (through data mining systems,[363] the development of 'suicide dictionaries'[364] and surveillance of factors associated with suicide by children and young people[365]) is capable of detecting children and young people at risk of suicide quickly, in real time, and on a large scale;

- many children and young people at risk of suicide prefer to seek help using the internet and social media, rather than through dedicated crisis hotlines;[366]

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[360] Australian Human Rights Commission, *Children's Rights Report 2014*, AHRC, Sydney, 2014, p. 109.

[361] Quinn K, 'Rural suicide and same-sex attracted youth: issues, interventions and implications for rural counsellors', *Rural and Remote Health*, 2003, vol. 3, no. 222, November 2003, viewed 18 March 2019, <https://www.rrh.org.au/journal/download/pdf/222/>.

[362] Intahchomphoo C, 'Social media and youth suicide: a systematic review', presented at the Twenty-Sixth European Conference on Information Systems (ECIS2018), Portsmouth, United Kingdom, 27 June 2018, viewed 2 April 2019, <http://ecis2018.eu/wp-content/uploads/2018/09/1119-doc.pdf>, p. 5.

[363] Chen P et al, 'Development and application of a Chinese webpage suicide information mining system (SIMS)', *Journal of Medical Systems*, vol. 38, no. 88, doi: 10.1007/s10916-014-0088-z; Li TM et al, 'Temporal and computerized psycholinguistic analysis of the blog of a Chinese adolescent suicide', *Crisis*, vol. 35, no. 3, January 2014, pp. 168-175; Cheng Q et al, 'Suicide communication on social media and its psychological mechanisms: An examination of Chinese microblog users', *International Journal of Environmental Research and Public Health*, vol. 12, no. 9, September 2015, pp.11506-11527, doi: 10.3390/ijerph120911506; Song J et al, 'Data mining of web-based documents on social networking sites that included suicide-related words among Korean adolescents', *Journal of Adolescent Health*, vol. 59, no. 6, December 2016, pp.668-673; Cheng Q et al, 'Assessing Suicide Risk and Emotional Distress in Chinese Social Media: A Text Mining and Machine Learning Study', *Journal of Medical Internet Research*, 2017, vol. 19, no. 7, e243, July 2017, doi: 10.2196/jmir.7276.

[364] Lv M et al, 'Creating a Chinese suicide dictionary for identifying suicide risk on social media', *PeerJ*, vol. 3, e:1455, December 2015, doi:10.7717/peerj.1455.

[365] Jashinsky J et al, 'Tracking suicide risk factors through Twitter in the US', *Crisis,* vol. 35, no. 1, January 2014, pp. 51-59.

[366] Crosby Budinger M, Cwik MF and Riddle MA, 'Awareness, attitudes, and use of crisis hotlines among youth at-risk for suicide', *Suicide and Life Threatening Behaviour*, vol. 45, no. 2, April 2015, pp. 192-198; Best P et al, 'Seeking help from everyone and no-one: conceptualizing the online help-seeking process among adolescent males,' *Qualitative Health Research*, vol. 26, no. 8, July 2016, pp. 1067-1077.

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- children and young people 'already are using the internet to access mental health information, and smartphone applications to help with self-care; however … young people tend to seek these out of their own accord, without direction from treating clinicians … [and] can find the abundance of information available online difficult to navigate or use helpfully';[367]

- 'young people can be safely engaged in the process of developing [social media-based] suicide prevention messages, which can be disseminated via social media. Engaging young people in this process may improve the traction that such campaigns will have with other young people. …educating young people regarding how to talk safely about suicide online has multiple benefits and is not associated with distress';[368] and

- a number of studies have observed links between increased social media use, including 'cyberbullying, sexting, and disseminating information about self-harm techniques and pro-suicide content on social media'[369] and disturbed sleeping patterns,[370] eating disorders,[371] anxiety, depression[372] and suicide risk.[373]

Social media use, including bullying, was mentioned in connection with 10 of the 115 children and young people (9 per cent) who died by suicide. On six occasions, social media was used to inform friends and family of a young person's suicidal intent. Online bullying was suggested as a factor relating to deaths of three young people. One young person died by suicide after repeated engagement with online media relating to suicide.

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[367] Fraser A et al, *E-mental health: the future of youth mental health?, Research Bulletin Issue 4*, Orygen, The National Centre of Excellence for Youth Mental Health, viewed 2 April 2019, <https://www.orygen.org.au/Education-Training/Resources-Training/Resources/Free/Research-Bulletins/E-mental-health-the-future-of-youth-mental-health>.
[368] Robinson J et al, 'Developing social media-based suicide prevention messages in partnership with young people: Exploratory study', *JMIR Mental Health*, vol. 4, no. 4:e40, December 2017, doi: 10.2196/mental.7847.
[369] Intahchomphoo C, 'Social media and youth suicide: a systematic review', presented at the Twenty-Sixth European Conference on Information Systems (ECIS2018), Portsmouth, United Kingdom, 27 June 2018, viewed 2 April 2019, <http://ecis2018.eu/wp-content/uploads/2018/09/1119-doc.pdf>, p. 5.
[370] Woods HC and Scott H, '#Sleepyteens: Social media use in adolescence is associated with poor sleep quality, anxiety, depression and low self-esteem', *Journal of Adolescence*, vol. 51, August 2016, pp. 41-49.
[371] Sidani JE, et al, 'The association between social media use and eating concerns among US young adults', *Journal of the Academy of Nutrition and Dietetics,* vol. 116, no. 9, September 2016, pp. 1465-1472.
[372] Primack B et al, 'Use of multiple social media platforms and symptoms of depression and anxiety: A nationally-representative study among US young adults', *Computers in Human Behavior*, vol. 69, April 2017, pp. 1-9.
[373] Twenge JM et al, 'Increases in depressive symptoms, suicide-related outcomes, and suicide rates among U.S. adolescents after 2010 and links to increased new media screen time', *Clinical Psychological Science,* vol. 6, no. 1, January 2018, pp. 3-17.

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4. Self-harm by children and young people in Western Australia

4.1 Introduction

> It is estimated that, for each suicide, there are likely to have been more than 20 suicide attempts. Having engaged in one or more acts of attempted suicide or self-harm is the single most important predictor of death by suicide.
>
> Consequently, long-term monitoring of the incidence, demographic patterns and methods involved in cases of attempted suicide and self-harm presenting at hospitals in a country or region provides important information that can assist in the development of suicide prevention strategies.
>
> By combining this information with information on suicide deaths, case fatality rates can be estimated which will assist in identifying high-risk individuals.[374]

The research literature differentiates self-harm and suicide attempts on the basis of frequency, method, severity and purpose, as summarised in Figure 39.

Figure 39: Differences in the frequency, method, severity and purpose of self-harm incidents and suicide attempts

	Self-Harm	**Suicide Attempts**
Frequency	Incidents are very frequent	Attempts occur less frequently
Method	Cutting, burning, self-hitting	Hanging, self-poisoning
Severity	Less severe, in most cases does not require medical treatment	Much more severe, often requires medical treatment to recover, sometimes lethal
Purpose	To cope with emotional pain and distress, feel better, communicate emotional pain, feel a sense of control, to punish themselves, or to avoid suicidal impulses	Intention to die

Sources: Orygen,[375] Klonsky, May and Glenn (2013)[376]

Although children and young people who self-harm may not attempt suicide, the research literature indicates self-harm is a significant risk factor for suicide,[377] and that:

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[374] World Health Organization, Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm, WHO, Geneva, 2016, p. 6.

[375] Hetrick S, *Suicide and Self-Harm in Adolescents, Presentation to the NZ Early Intervention in Psychosis Training Forum*, November 2017, viewed 19 March 2019, <https://www.tepou.co.nz/uploads/files/resource-assets/Sarah%20Hetrick%20-%20Suicide%20and%20self-harm%20in%20adolescents.pdf>.

[376] Klonsky E, May A, and Glenn C, 'The relationship between nonsuicidal self-injury and attempted suicide: Converging evidence from four samples', *Journal of Abnormal Psychology*, vol. 122, no. 1, February 2013, pp. 231-237.

[377] Hawton, K, Saunders, KEA, and O'Connor, RC, 'Self-harm and suicide in adolescents', *Lancet*, vol. 379, no. 9834, 23 June 2012, pp. 2373-2382.

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- young people who self-harm are 100 times more likely to die by suicide in the following 12 month period than young people who have not self-harmed;[378] and

- almost half of young people who self-harm also report at least one suicide attempt.[379]

The research literature notes that the current evidence base for self-harm by children and young people comprises data on emergency department presentations, hospital admissions and information obtained through self-reporting surveys. However, these sources do not capture the full extent and prevalence of these issues in the community:

> Due to the stigma associated with self-harm, many young people do not present for help or disclose their behaviour. For particular groups, including young women, Aboriginal and Torres Strait Islander (ATSI) young people and young people with mental illness, the rates are much higher. For example, the rates of self-harm hospitalisation for 15-24 year old Aboriginal and Torres Strait Islanders is over five times that of non-Indigenous young people in the same age group. …
>
> It is, however, incorrect to assume that hospital admissions data reflect either the extent or nature of self-harm in Australia. Hospitalisation rates for self-harm also reveal only the very tip of the iceberg, as most instances of self-harm do not require medical treatment and many presentations to emergency departments do not result in a hospital admission. As identified in the National Mental Health Commission Review, there is a lack of data collection on emergency department presentations by people with suicide-related behaviours, including self-harm.
>
> Further, while Australian and international hospital data indicate most hospital admissions are for episodes of self-poisoning (particularly overdosing on analgesics such as paracetamol), in the community the situation is reversed and self-cutting and other forms of self-mutilation are reported more frequently than self poisoning.[380]

4.1.1 Self-harming and suicidal behaviour

The 2014 Investigation found that:

- 42 per cent of the 36 young people were recorded as demonstrated self-harming behaviour; and

- 44 per cent of the 36 young people were recorded as having previously attempted suicide.

Similar rates of recorded self-harming behaviour and previous suicide attempts were also found among the 79 children and young people, with a total of 40 of the 115 children and

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[378] Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 20.

[379] Centre for Suicide Prevention, *Self-harm and Suicide: A suicide prevention toolkit*, Canadian Mental Health Association, viewed 19 March 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/10/Self-Harm-Toolkit.pdf>, p. 5, citing Klonsky E et al, *Nonsuicidal self-injury*, Hogrefe Publishing, Toronto, 2011; Klonsky E, 'The functions of deliberate self-injury: a review of the evidence', *Clinical Psychology Review*, 2007, vol 27, no. 2, pp. 226-239; Klonsky E et al., 'Nonsuicidal self-injury: what we know, and what we need to know', *Canadian Journal of Psychiatry*, vol. 59, no. 11, 2014, pp. 565-568.

[380] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, pp. 5 and 12.

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young people (35 per cent) known to have self-harmed during their lives. Considering this continuing trend in the current investigation, the relevant research literature and in an effort to better understand the relationship between self-harm and suicide in children and young people in Western Australia, the Office obtained data from the Department of Health relating to hospital admissions and emergency department attendances for non-fatal intentional self-harm. This chapter considers the characteristics of the children and young people who were admitted to hospital or attended an emergency department for self-harm in Western Australian between 1 July 2009 and 30 June 2018.

4.2 Circumstances of self-harm that led to hospital admission or attendance at an emergency department

4.2.1 Summary of self-harm that led to hospitalisation of children and young people in Western Australia

Over the 9 year period from 1 July 2009 to 30 June 2018, there were 5,142 hospital admissions relating to self-harm[381] in Western Australia. Hospital admissions for self-harm increased by 64 per cent from 2009-10 to 2017-18 (from 411 to 672 admissions, or 261 admissions in total).

Figure 40 provides a summary of the circumstances of self-harm that led to hospital admission over the 2009-10 to 2017-18 period.

Figure 40: Summary of self-harm hospitalisations, children and young people, Western Australia, 2009-10 to 2017-18

	Hospital admissions	
	Number	**Per cent**
	5,142	**100%**
Month[382]		
January	356	7%
February	429	8%
March	491	10%
April	443	9%
May	483	9%
June	432	8%
July	323	6%
August	486	9%
September	435	8%
October	458	9%
November	461	9%
December	345	7%

---

[381] That is, admissions where the ICD-10 external cause code was X60-X84 or Y87.

Hospital admissions		
	Number	**Per cent**
	5,142	**100%**
Method		
Poisoning	3,467	67%
Nonopioid analgesics, antipyretics and antirheumatics	1,128	33% (of all poisonings)
Antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	461	13% (of all poisonings)
Other and unspecified drugs, medicaments and biological substances	211	6% (of all poisonings)
Cutting or other contact with a sharp object	1,141	22%
Hanging	228	4%
Other	265	5%
Falls	19	0.4%
Principal Diagnosis		
Paracetamol toxicity	1,128	22%
Poisoning by antipsychotic and neuroleptic drugs	461	9%
Poisoning by other and unspecified antipsychotics and neuroleptics	211	4%
Acute stress reaction	210	4%
Poisoning by nonsteroidal anti-inflammatories	167	3%
Other	2,965	58%
Location of self-harm (where specified)		
Home, unspecified	1,576	56%
Health service area	461	16%
Bedroom	171	6%
School	131	5%
Other	462	17%
Unspecified	2,341	(not included in percentages)
Duration of stay		
Less than 4 days	4,125	80%
4-7 days	413	8%
8-14 days	380	7%
More than 14 days	224	4%
Discharge		
Home	4,155	81%
Other acute hospital	703	14%
Against medical advice/at own risk	80	2%
Other	204	3%

Source: Ombudsman Western Australia, Department of Health

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4.2.2 Method of self-harm

As shown in Figure 41, most hospital admissions for self-harm by children and young people were due to intentional self-poisoning (3,467 admissions or 67 per cent), in particular by:

- nonopioid analgesics, antipyretics and antirheumatics (1,128 admissions, or 33 per cent of poisonings); and

- antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified (461 admissions, or 13 per cent).

In 22 per cent of the 5,142 admissions, children and young people were recorded as having a principal diagnosis of paracetamol toxicity (1,128 admissions). The second most frequent principal diagnosis was poisoning by antipsychotic and neuroleptic drugs (461 admissions or 9 per cent), followed by antipsychotic and neuroleptic drugs (211 admissions, 4 per cent). Acute stress reactions accounted for 210 primary diagnoses for the children and young people (210 admissions, 4 per cent).

In non-poisoning admissions, contact with a sharp object was the most common mechanism of self-harm, comprising 22 per cent (1,141) of total admissions of children and young people.

Figure 41: Method of self-harm, used by the children and young people who were hospitalised[383]
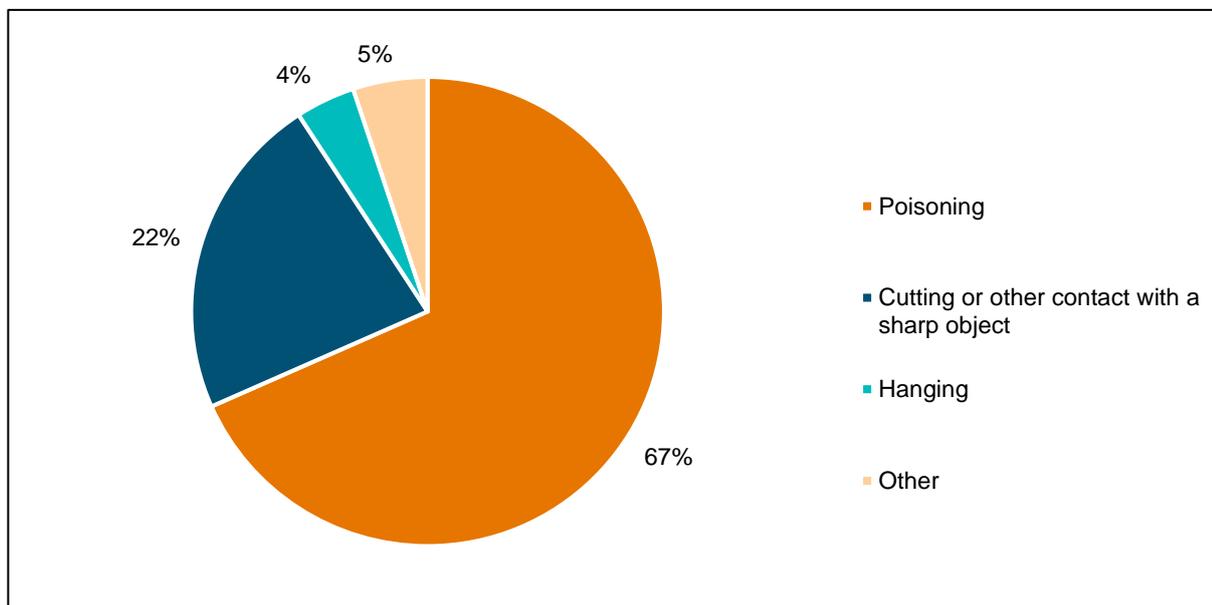
Source: Ombudsman Western Australia, Department of Health

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[383] ICD-10 codes reflecting the mechanism of intentional self-harm were aggregated and categorised in a manner consistent with Australian Bureau of Statistics, *Causes of Death, Australia, 2014*, cat no. 3303.0, ABS, Canberra, March 2016. Some mechanisms of intentional self-harm have been omitted from analyses as they occurred infrequently over the time period.

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4.2.3   Location of self-harm

Where admission records specified a place of occurrence for a child or young person's self-harming behaviours, the majority occurred within the home (56 per cent or 1,576 of the 2,801 admissions with a location recorded). Health service areas (461 admissions, 16 per cent), bedrooms (171 admissions, 6 per cent) and school (131 admissions, 5 per cent) were the other most frequently disclosed locations for children and young people to self-harm (Figure 42).

Figure 42: Location of self-harm, for the children and young people who were hospitalised
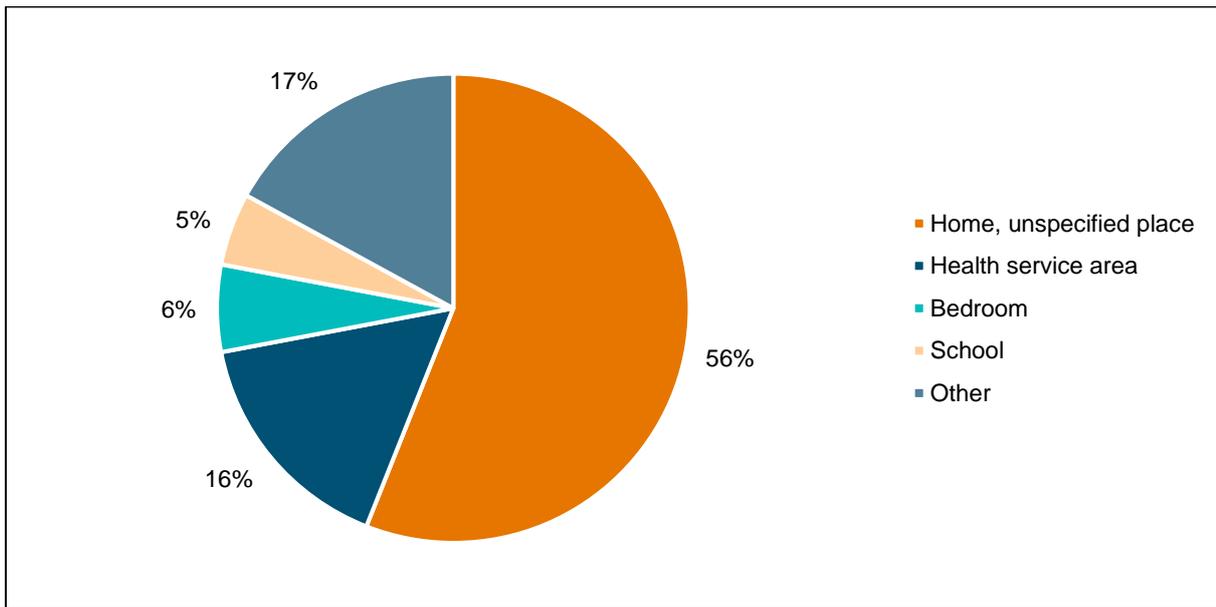
Source: Ombudsman Western Australia, Department of Health

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4.3   Characteristics of the children and young people who self-harm

Figure 43 shows the circumstances and characteristics for the children and young people of the 5,142 admissions to hospital and of the 17,115 attendances to emergency departments associated with self-harm. A more comprehensive analysis of the circumstances and characteristics associated with each admission or attendance is provided in subsequent sections.

Figure 43: Characteristics of children and young people at first hospital admission or attendance at an emergency department for self-harm, 6 to 17 years, Western Australia, 2009-10 to 2017-18

	Hospital admissions		Emergency department attendances	
	5,142 admissions		17,115 attendances	
Year	Number	Percentage of children and young people	Number	Percentage of children and young people
2009-10	333	9%	581	6%
2010-11	352	9%	653	7%
2011-12	380	10%	792	8%
2012-13	571	15%	1,097	11%
2013-14	417	11%	996	10%
2014-15	385	10%	1,049	11%
2015-16	417	11%	1,213	12%
2016-17	436	12%	1,595	16%
2017-18	425	11%	1,974	20%
TOTAL	**3,716**	**children and young people**	**9,950**	**children and young people**
Sex				
Female	2,935	79%	6,532	66%
Male	781	21%	3,414	34%
Not stated/recorded	-	-	4	(not included))
Aboriginality				
Aboriginal and/or Torres Strait Islander	322	9%	938	10%
Female	240	75%	570	61%
Male	81	25%	368	39%
Non-Aboriginal	3394	91%	8,852	90%
Female	2695	79%	5,851	66%
Male	699	21%	3,001	34%
Unknown	-	-	158	(not included)
Not stated/recorded			2	
Age at date of first admission or emergency department attendance				
≤11 years	30	1%	521	5%
12 years	76	2%	403	4%
13 years	261	7%	848	9%
14 years	563	15%	1,594	16%
15 years	793	21%	2,128	21%
16 years	1054	28%	2,184	22%
17 years	939	25%	2,272	23%
Not recorded	-	-		
Remoteness of Residence				
Major Cities	2,566	69%	8,054	83%
Inner Regional	371	10%	782	8%
Outer Regional	429	12%	456	5%
Remote	173	5%	221	2%
Very Remote	151	4%	187	2%
Other/Unknown/Not Recorded	26	(not included)	250	-

Source: Ombudsman Western Australia and the Department of Health

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4.4 Hospital admissions for self-harm and suicidal behaviour by children and young people in Western Australia

4.4.1 Prevalence of self-harm related hospital admissions of children and young people in Western Australia

There were 3,716 children and young people between the ages of 6 and 17 years, admitted to hospital on 5,142 occasions for self-harm in Western Australia from 1 July 2009 to 30 June 2018.[384] The highest number of individual children and young people over the 9 year period was 571 in 2012-13, with the lowest being 333 in 2009-10, and an average yearly total number of self-harm related hospital admissions of 571.

Figure 44: Individual children and young people who self-harmed, 2009-10 to 2017-18, by year of first hospital admission
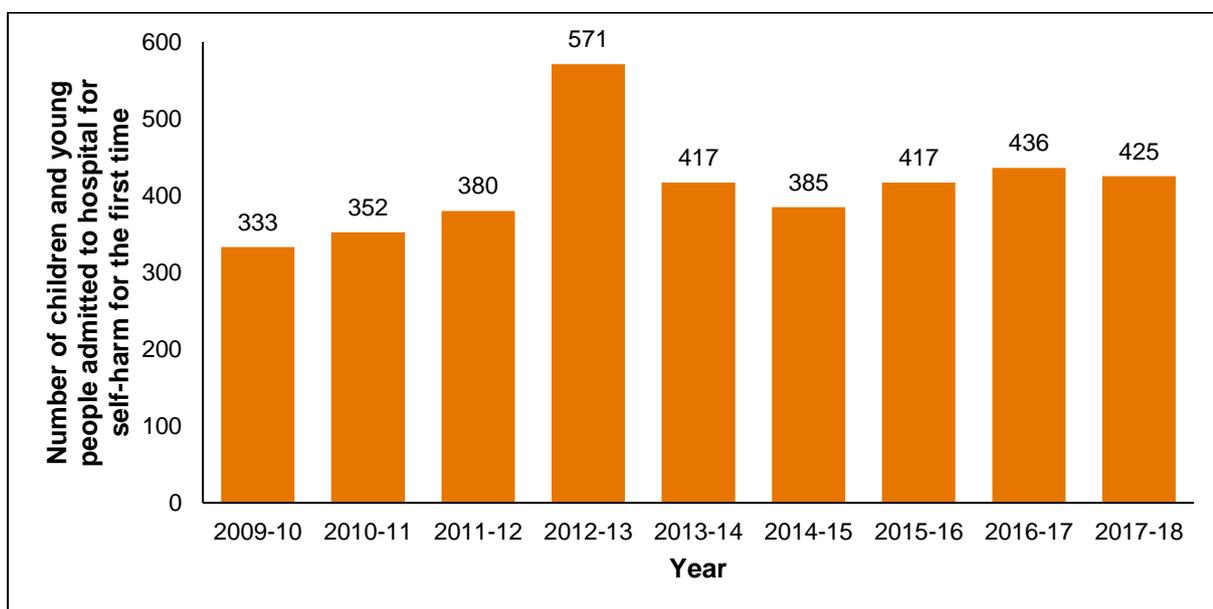
Source: Ombudsman Western Australia, Department of Health

Figure 45 highlights that there was a large increase in the number of children and young people admitted to hospital for self-harm in 2012-13. The Commissioner for Children and Young People's also observed an increase in self-harm in 2012-13 and noted in *The State of Western Australia's Children and Young People* that:

> The age-adjusted rate (AAR) per 100,000 young people aged 13 to 17 years fluctuated between 2005 and 2011 with a low of 127.5 in 2008 and a peak of 253.8 in 2012.
>
> The recent increase is accounted for by both genders: the number of hospitalisations increased by 31.4 per cent for males and by 68.3 per cent for females from 2011 to 2012 ... Tracking of future years will be required to see if this increase represents a continuing trend rather than a peak in a fluctuating pattern. However, contacts with the Kids Helpline from young people

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[384] The data reflects records in the Department of Health's Hospital Morbidity Data Collection as at 18 July 2018. Data from May 2018 onwards is not complete. Accordingly, the number of hospital admissions for intentional self-harm in the 2017-18 financial year may be slightly underestimated.

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regarding issues with self-harm have shown an upward trend over the last three years with the numbers doubling between 2009 and 2012.[385]

The increase in hospitalisations in 2012-13 appears to have also occurred nationally, with a total of 6,059 self-harm injury hospitalisation cases for children and young people in Australia in 2012-13.[386] Figure 45 shows that the number of hospital admissions for self-harm over the 9 years varied from 411 in 2009-10 to 672 in 2017-18, peaking at 790 admissions in 2012-13.

Figure 45: Hospital admissions, for the children and young people
who self-harmed, Western Australia, 2009-10 to 2017-18, by year
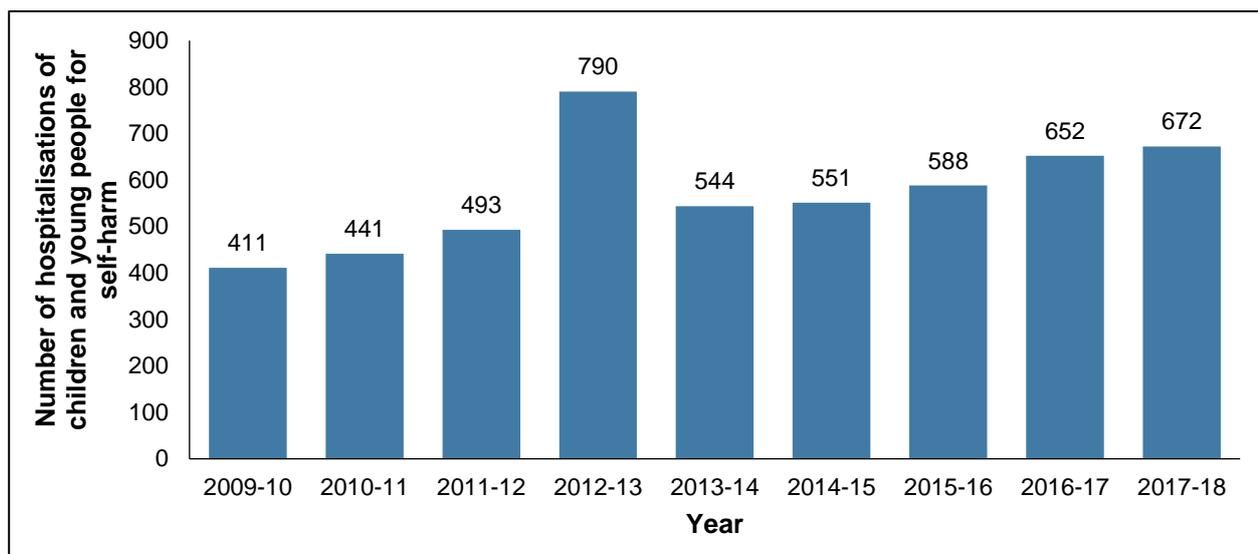
Source: Ombudsman Western Australia, Department of Health

Kids Helpline observed a similar trend in increasing contact with their service about mental health and suicide concerns over the two decades from 1996 to 2015, and relevantly have observed that:

> WHY DID MENTAL HEALTH AND SUICIDE CONTACTS INCREASE?
>
> It may seem logical to conclude from this data that there has been an explosion in mental health and suicide concerns over the last two decades. While there may be genuine increases in these needs, other factors have contributed to these results.
>
> Over the last 20 years, and particularly over the last 10 years, there has been growing awareness and increasing acceptance of mental health issues in the community. This social and cultural change is likely to have increased children and young people's recognition of these issues and their willingness to seek help.[387]

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[385] Commissioner for Children and Young People Western Australia, *The State of Western Australia's Children and Young People – Edition Two*, Subiaco, 2014, pp. 113 – 114.

[386] Australian Institute of Health and Welfare, 'Data table: Chapter 11 Intentional self-harm', *Trends in hospitalised injury, Australia 1999-00 to 2014-15*, viewed 4 May 2019, <https://www.aihw.gov.au/reports/injury/trends-in-hospitalised-injury-1999-00-to-2014-15/data>.

[387] Your Town, *Kids Helpline Insights 2015: Insights Into Young People in Australia*, yourtown, Milton, Queensland, 2016, viewed 4 May 2019, <https://www.yourtown.com.au/sites/default/files/document/BST6407_KHL%20Insights%20Report%202016.pdf>, p. 21.

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Research from the United States (**US**) recently considered five suggested 'causes' for rising rates of mental health issues among teenagers, including the:

- Global Financial Crisis (**GFC**) and cyclical economic factors;

- income inequality and other noncyclical economic factors;

- changes in the amount of homework and extracurricular activities;

- rates of drug and alcohol abuse; and

- smartphones and social media.[388]

However, subsequent research identified that:

- rates of self-harm in the US continued to increase even as the US economy improved following the GFC;[389]

- income inequality and job instability has been increasing since the 1970s at roughly the same rates. However, the increase in self-harm was largest among 10 to 14 year olds, the age group least likely to work; [390]

- teenagers are doing fewer hours of homework today than in the 1980s, while time spent on extracurricular activities is stable, confirming earlier research which found that teenagers who spend more time on homework and sports are less likely to be depressed;[391]

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[388] Mercado M, Holland K and Leemis R et al, 'Trends in Emergency Department Visits for Nonfatal Self-inflicted Injuries Among Youth Aged 10 to 24 Years in the United States, 2001-2015', *Journal of the American Medical Association*, vol. 318, no. 19, pp. 1931-1933, doi: 10.1001/jama.2017.13317.

[389] Twenge J, 'iGen: Why Today's Super-Connected Kids are Growing up Less Rebellious, More Tolerant, Less Happy – and Completed Unprepared for Adulthood and What That Means for the Rest of Us', *Simon and Schuster*, 22 August 2017, viewed 6 May 2019, <http://www.jeantwenge.com/wp-content/uploads/2017/08/igen-appendix.pdf>, p. 29 (Appendices); and Twenge J, '5 Reasons Why Self-Harm and Depression Have Tripled in Girls: Possible Causes behind the increase were found by the CDC', *Psychology Today*, 21 November 2017, viewed 6 May 2019, <https://www.psychologytoday.com/au/blog/our-changing-culture/201711/5-reasons-why-self-harm-and-depression-have-tripled-in-girls>.

[390] Twenge J, 'iGen: Why Today's Super-Connected Kids are Growing up Less Rebellious, More Tolerant, Less Happy – and Completed Unprepared for Adulthood and What That Means for the Rest of Us', *Simon and Schuster*, 22 August 2017, viewed 6 May 2019, <http://www.jeantwenge.com/wp-content/uploads/2017/08/igen-appendix.pdf>, p. 29 (Appendices); and Twenge J, '5 Reasons Why Self-Harm and Depression Have Tripled in Girls: Possible Causes behind the increase were found by the CDC', *Psychology Today*, 21 November 2017, viewed 6 May 2019, <https://www.psychologytoday.com/au/blog/our-changing-culture/201711/5-reasons-why-self-harm-and-depression-have-tripled-in-girls>.

[391] Twenge J, 'iGen: Why Today's Super-Connected Kids are Growing up Less Rebellious, More Tolerant, Less Happy – and Completed Unprepared for Adulthood and What That Means for the Rest of Us', *Simon and Schuster*, 22 August 2017, viewed 6 May 2019, <http://www.jeantwenge.com/wp-content/uploads/2017/08/igen-appendix.pdf>, p. 29 (Appendices); and Twenge J, '5 Reasons Why Self-Harm and Depression Have Tripled in Girls: Possible Causes behind the increase were found by the CDC', *Psychology Today*, 21 November 2017, viewed 6 May 2019, <https://www.psychologytoday.com/au/blog/our-changing-culture/201711/5-reasons-why-self-harm-and-depression-have-tripled-in-girls>.

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- substance abuse has declined among teenagers in the US during the time self-harm increased, making it unlikely to be the cause; [392] and

- smartphone ownership and screen time rose at the same time as self-harm and appear to be linked to the mental health issues that often co-occur with self-harm. However increased screen time was the largest change in teenagers' lives between 2011 and 2015, rising to an estimated six to nine hours per day – leaving less time for activities that are beneficial for mental health such as sleep and seeing friends in person. [393]

4.4.2   Characteristics of the children and young people who self-harmed and were admitted to hospital

4.4.2.1   Age

In Australia, self-harm among children and young people is a significant public health issue, with approximately 11.6 per cent of 11 to 16 year olds and 18.1 per cent of 20 to 24 year olds reporting that they have self-harmed during their lives.[394] An Australian study found that approximately 7.6 per cent of children 10 to 12 years reported self-harm.[395]

Between 2009-10 and 2017-18, 367 children aged 6 to 13 years and 3,349 young people aged 14 to 17 years were admitted to hospital for self-harm and/or suicidal behaviours for the first time (Figure 46).

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[392] Twenge J, 'iGen: Why Today's Super-Connected Kids are Growing up Less Rebellious, More Tolerant, Less Happy – and Completed Unprepared for Adulthood and What That Means for the Rest of Us', *Simon and Schuster*, 22 August 2017, viewed 6 May 2019, <http://www.jeantwenge.com/wp-content/uploads/2017/08/igen-appendix.pdf>, p. 29 (Appendices); and Twenge J, '5 Reasons Why Self-Harm and Depression Have Tripled in Girls: Possible Causes behind the increase were found by the CDC', *Psychology Today*, 21 November 2017, viewed 6 May 2019, <https://www.psychologytoday.com/au/blog/our-changing-culture/201711/5-reasons-why-self-harm-and-depression-have-tripled-in-girls>.

[393] Twenge J, 'iGen: Why Today's Super-Connected Kids are Growing up Less Rebellious, More Tolerant, Less Happy – and Completed Unprepared for Adulthood and What That Means for the Rest of Us', *Simon and Schuster*, 22 August 2017, viewed 6 May 2019, <http://www.jeantwenge.com/wp-content/uploads/2017/08/igen-appendix.pdf>, p. 29 (Appendices); and Twenge J, '5 Reasons Why Self-Harm and Depression Have Tripled in Girls: Possible Causes behind the increase were found by the CDC', *Psychology Today*, 21 November 2017, viewed 6 May 2019, <https://www.psychologytoday.com/au/blog/our-changing-culture/201711/5-reasons-why-self-harm-and-depression-have-tripled-in-girls>.

[394] Martin G, et al, 'Self-injury in Australia: a community survey', *Medical Journal of Australia*, vol. 193, no. 9, pp. 506-510.

[395] headspace School Support, *Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary,* <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res2.pdf>, p. 3, citing Swannell S, and Martin G, 'Self-injury and suicidality among Australian middle school students', 2014 (unpublished).

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Figure 46: Age at first self-harm hospital admission, for the children and young people who self-harmed
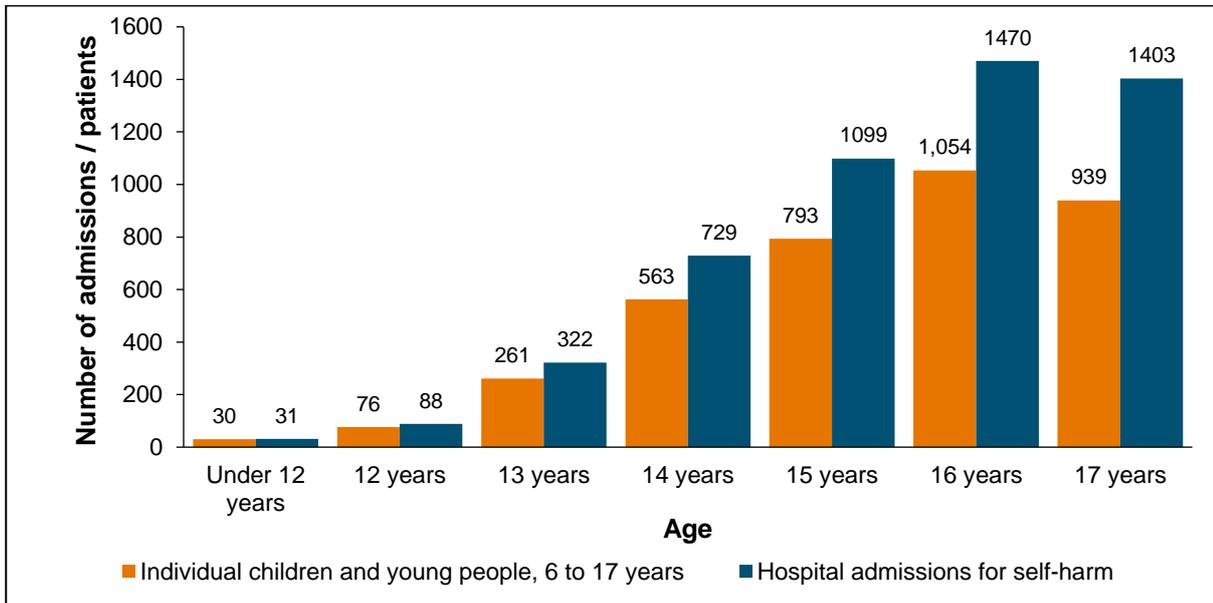
These 3,716 children and young people were 0.8 per cent of the total population of individual children and young people aged 6 to 17 years in WA over the same period (482,285). The average age of children and young people at their first admission for self-harm was 15 years 6 months. Three quarters (75 per cent) of children and young people admitted to hospital for self-harm were aged between 15 and 17 when first admitted (Figure 47).

Figure 47: Hospital admissions, for the children and young people who self-harmed, by age at first hospitalisation
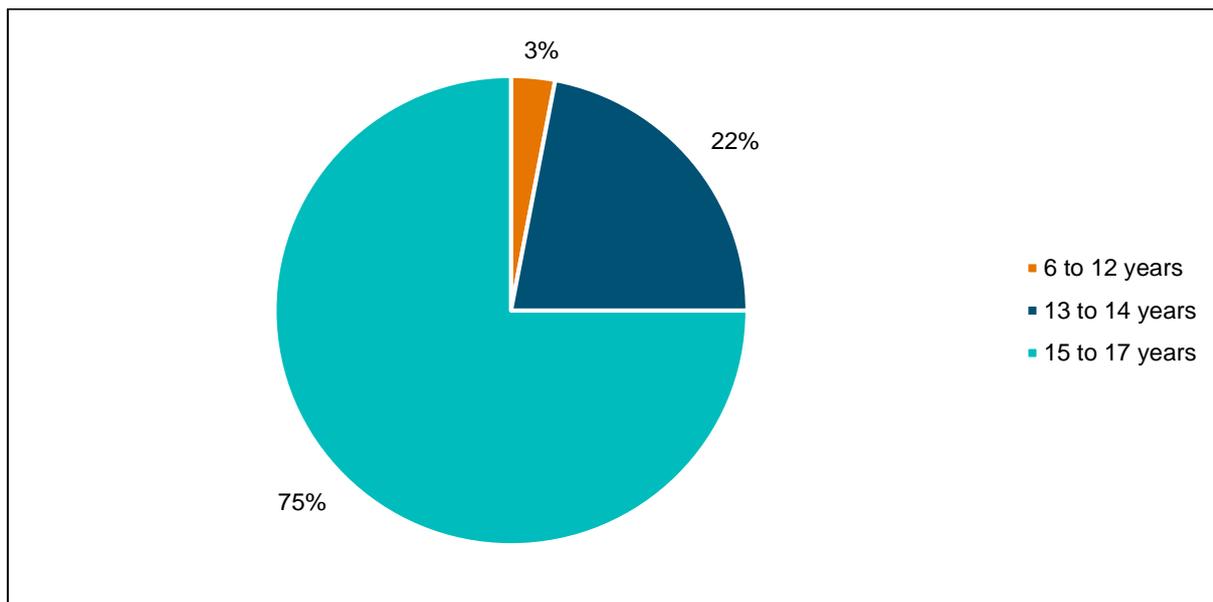
The number of hospital admissions due to self-harm increased for most age groups between 2009-10 and 2017-18. Fifteen year old young people demonstrated the largest

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increase. Figure 48 provides the Western Australian age-specific rates of hospitalisations of children aged 6 to 13 years and young people between the ages of 14 and 17, for self-harming or suicidal behaviour over the 2009-10 to 2017-18 period.

Figure 48: Age-specific hospital admission rates, for the children and young people who self-harmed, 6 to 17 years, Western Australia, 2009-10 to 2017-18, by age group and number of admissions
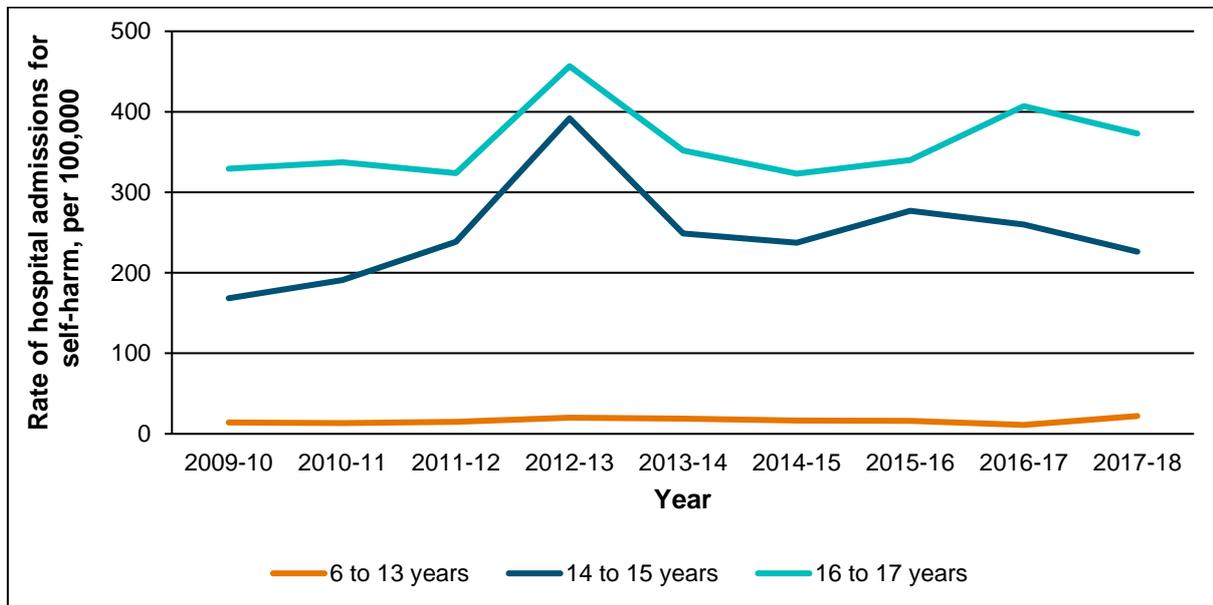
Source: Ombudsman Western Australia, Department of Health

4.4.2.2   Sex

Young women are generally over-represented in prevalence statistics relating to self-harm, however the research literature:

> … suggests caution in viewing self-harm as a greater problem for young women… Young males engage in different sorts of self-harm such as hitting or breaking bones, which receives a different sort of attention and can sometimes be explained by an accident or a fight.[396]

Most hospital admissions were for female children and young people. Of the 5,142 hospital admissions due to self-harm, 4,167 (81 per cent) were female and 975 (19 per cent) were male. Similarly, of the 3,716 individual children and young people hospitalised due to self-harm, 2,935 (79 per cent) were female and 781 (21 per cent) were male.

The higher frequency of female children and young peoples' admission to hospital for self-harm was consistent across every age group, except children aged under 11 years (where 18 male children were admitted on 18 occasions, compared to 12 female children) as shown in Figure 49.

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[396] Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 17.

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Figure 49: Individual children and young people who self-harmed and were admitted to hospital, by sex and age group
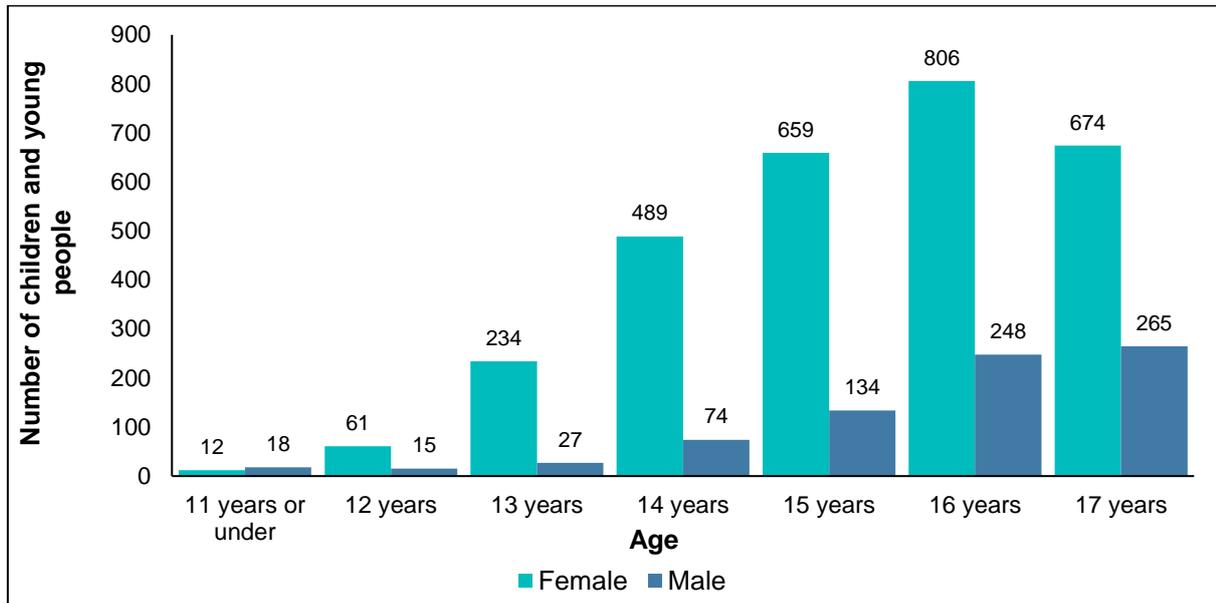
Source: Ombudsman Western Australia, Department of Health

As seen in Figure 50, the age-specific rate for children and young people aged 6 to 17 years remained relatively stable amongst males, however increased by 54 per cent for female children and young people. This has led to an increased rate in the 6 to 17 year old age group, from 94.8 children and young people hospitalised per 100,000 in 2009-10 to 133.5 per 100,000 in 2017-18 (41 per cent).

Figure 50: Age-specific rate, children and young people who self-harmed and were admitted to hospital, by sex and year, per 100,000

Year	Female 6-17 years	Male 6-17 years	Total 6-17 years
2009-10	145.8	46.2	94.8
2010-11	162.4	55.7	107.9
2011-12	184.7	49.4	115.6
2012-13	288.1	64.0	173.7
2013-14	214.9	43.7	127.5
2014-15	200.7	47.4	122.4
2015-16	214.6	48.4	129.6
2016-17	226.7	43.8	133.2
2017-18	225.2	45.9	133.5

Source: Ombudsman Western Australia, Department of Health

Although there has been more variation in the rate of female children and young people hospitalised for self-harm, trends over the 9 years are similar across both sexes, as shown in Figure 51:

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Figure 51: Age-specific self-harm hospitalisation rate, children and young people, Western Australia 2009-10 to 2017-18, by sex
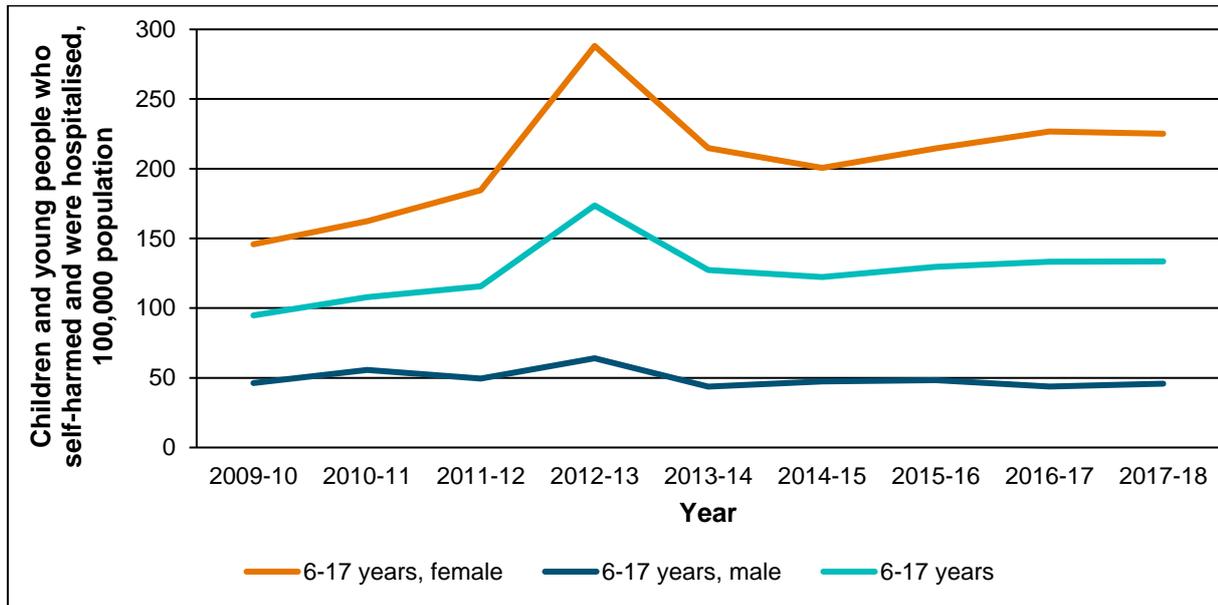
Source: Ombudsman Western Australia, Department of Health

4.4.2.3   Remoteness of residence

As shown in Figure 52, most children and young people admitted to hospital for self-harm were from the Perth metropolitan area (2,566 children and young people, 69 per cent). These children and young people also accounted for 3,726 admissions (72 per cent).

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Figure 52: Remoteness of residence, for the children and young people who self-harmed and were admitted to hospital, at their first admission, 2009-10 to 2017-18, Western Australia[397]
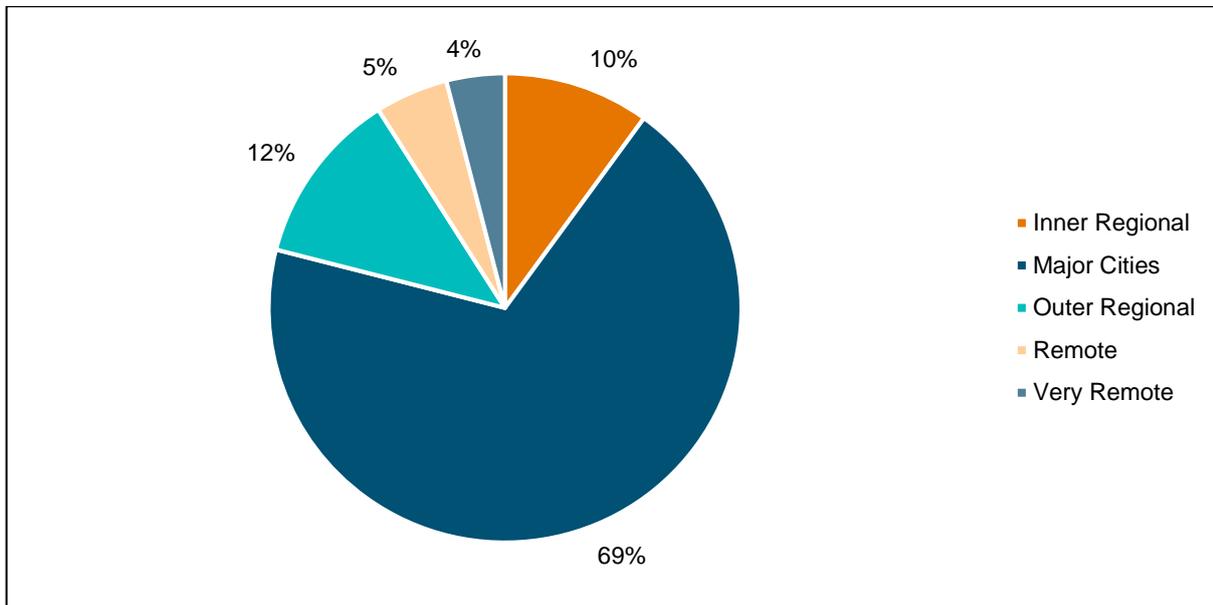
As shown in Figure 53, however, children and young people from regional and remote areas were over-represented when compared to the proportion of the Western Australian children and young people living in these regions. A total of 1,124 children and young people from regional and remote areas were admitted to hospital for self-harm (31 per cent) and were admitted to hospital on 1,379 occasions.

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[397] The Office categorised the usual residence of the children into 'Remoteness Areas' as defined by the Australian Bureau of Statistics' Australian Statistical Geography Standard. For more information see: Australian Bureau of Statistics, *Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure*, cat. no. 1270.0.55.005, ABS, Canberra, July 2011.

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Figure 53: Remoteness of residence, for the children and young people who self-harmed and were admitted to hospital, at their first admission, Western Australia, 2009-10 to 2017-18,[398]
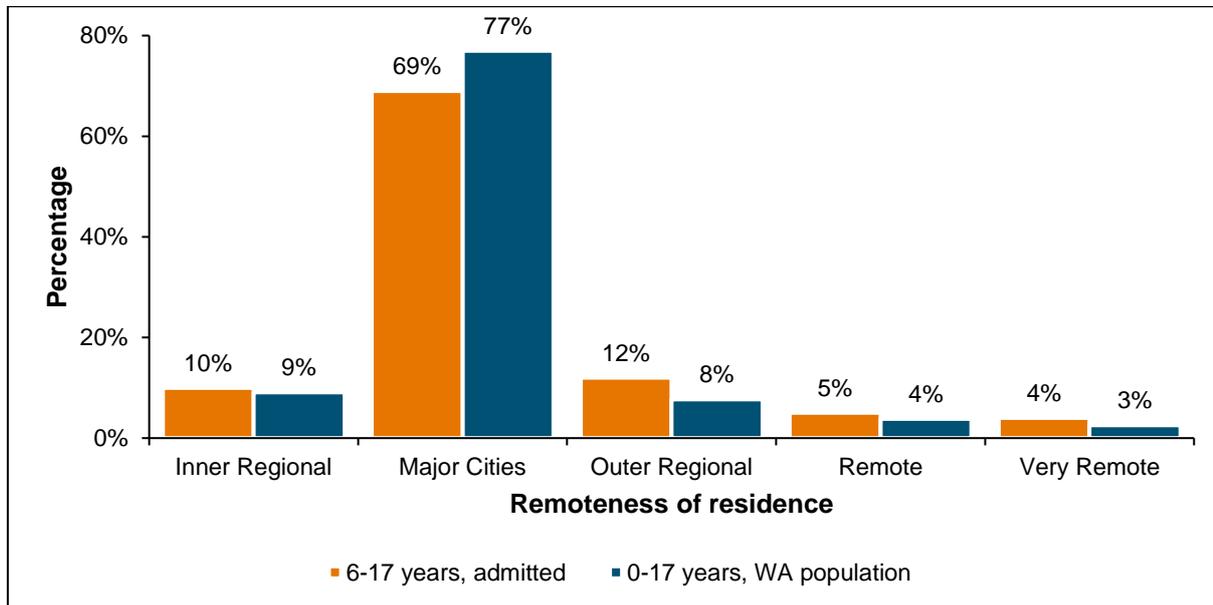
Source: Ombudsman Western Australia, Department of Health

4.4.2.4   *Aboriginal and/or Torres Strait Islander children and young people*

Aboriginal and/or Torres Strait Islander children and young people were over-represented among the admissions for self-harm, when compared to the Western Australian 6 to 17 years population. A total of 327 Aboriginal and/or Torres Strait Islander children and young people (9 per cent) were admitted to hospital for self-harm on 389 occasions (8 per cent of all admissions). By way of comparison, Aboriginal and/or Torres Strait Islander children and young people make up 7 per cent of the child and young person population in Western Australia.

The number of hospital admissions for self-harm among Aboriginal and/or Torres Strait Islander children and young people increased from 26 (of 411 admissions, 7 per cent) in 2009-10 to 59 (of 672 admissions, 10 per cent) in 2017-18.

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[398] To determine the population of children aged 0 to 17 in each 'Remoteness Area' the Office used a 2016 Census General Community Profile Remoteness Area for WA DataPack from the Australian Bureau of Statistics.

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Figure 54: Children and young people admitted to hospital for self-harm, by year and Aboriginality
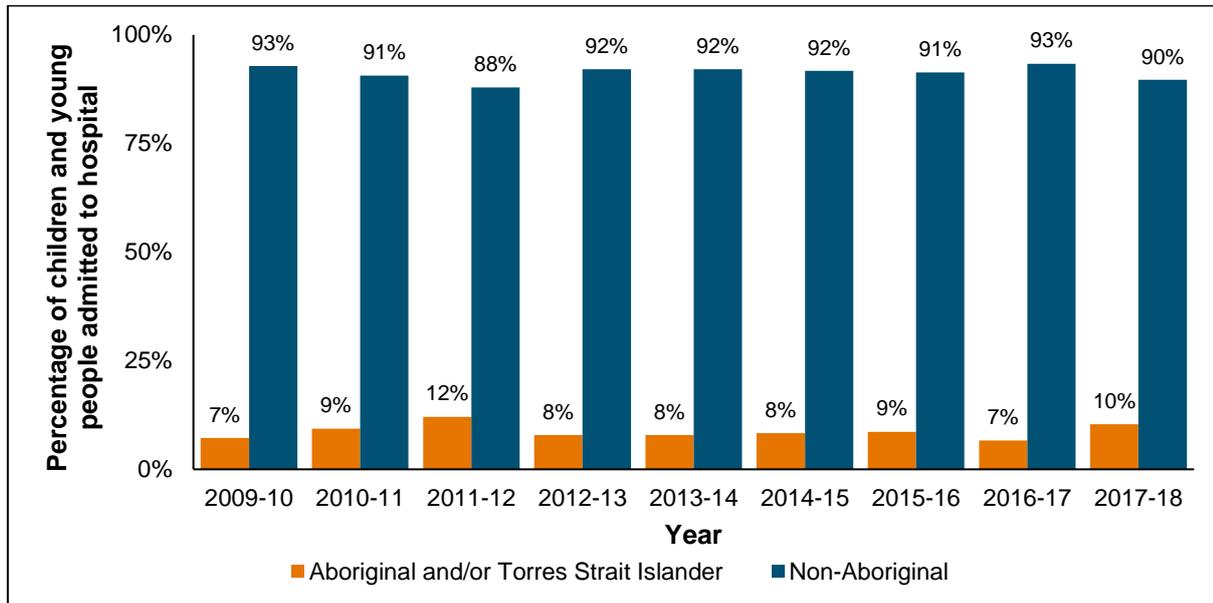
Source: Ombudsman Western Australia, Department of Health

4.4.2.5   Duration of hospital stay

As shown in Figure 55 the majority of children and young people admitted to hospital in relation to self-harm spent up to three days in hospital prior to separation from the hospital.

Figure 55: Duration of stay, children and young people hospitalised for self-harm, Western Australia 2009-10 to 2017-18

Source: Ombudsman Western Australia, Department of Health

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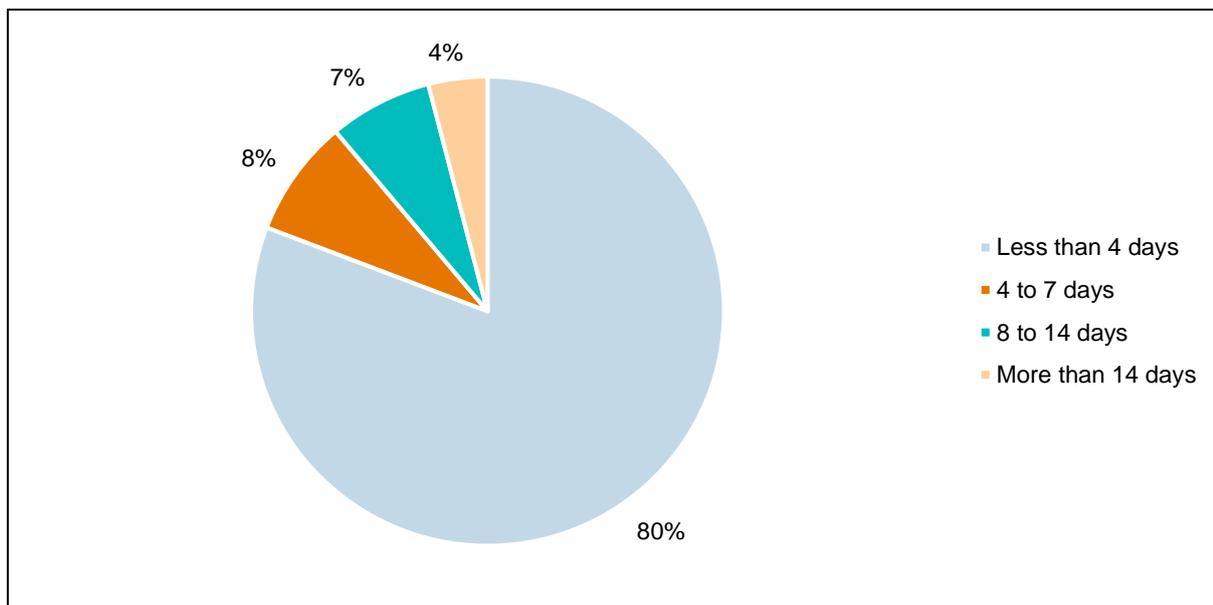
4.4.2.6   Repeated hospital admissions

Most children and young people (2,976 children and young people, 80 per cent) were admitted to hospital for self-harm only once between 2009-10 to 2017-18. A small proportion (85 children and young people, 2 per cent) were admitted on five or more occasions, accounting for 600 admissions or 12 per cent.

4.5   Self-harm related emergency department attendances

4.5.1   The Department of Health has improved its emergency department data collection practices to include all metropolitan and regional and remote emergency departments since the 2016-17 financial year

The Department of Health provided the Office with data from its Emergency Department Data Collection (as at 18 July 2018) for each emergency department attendance by a child or young person between 1 July 2009 to 30 June 2018 where the recorded diagnosis[399] related to self-harm or suicidal ideation.

The data excludes children and young people that:

- died in the emergency department;

- were discharged from an emergency department and admitted to hospital on the same day; and

- were aged under six years.

Some variation in this emergency department attendance data over time is attributable to improvements in data collection practices. Particularly in regional and remote hospitals where emergency department attendance data has only been consistently captured as part of the Department of Health's Emergency Department Data Collection since the start of the 2016-17 financial year. As approximately 22 per cent of Western Australian children and young people reside outside of the metropolitan area, these variations in state-wide data collection indicate that:

- emergency attendance data from 2009 to 2016 is underestimated; and

- the associated differences in emergency department attendance data over time are inflated.

4.5.2   Prevalence of emergency department attendances for self-harm and suicidal behaviour by children and young people in Western Australia

There were 17,115 emergency department attendances by children and young people in Western Australia between 1 July 2009 and 30 June 2018 where the recorded diagnosis related to self-harm. As shown in Figure 56, the number of emergency department attendances where the recorded diagnosis related to self-harm increased over this time period, from 831 in 2009-10 to 3,362 in 2017-18. As seen in Figure 56, emergency department attendances increased in 2012-13, similar to hospital admissions, and have continued to increase from 2013-14 to 2017-18.

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[399] In the Department of Health Emergency Department Data Collection, this field is named 'episode diagnosis'.

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Figure 56: Emergency department attendances, for the children and young people who self-harmed, 2009-10 to 2017-18, by year
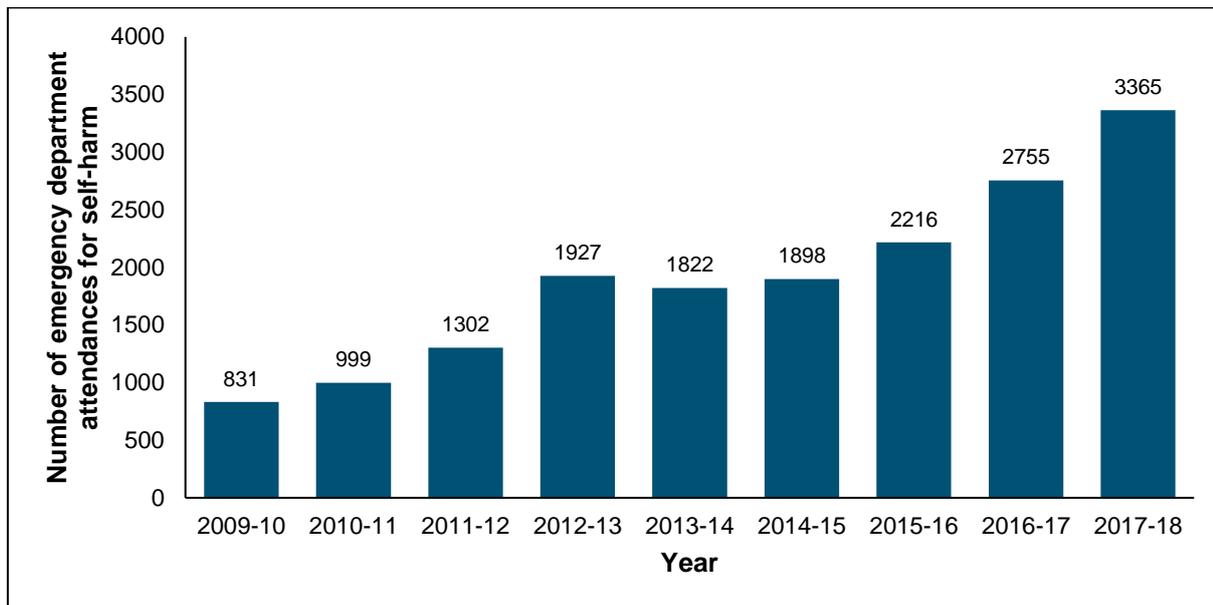
Source: Ombudsman Western Australia, Department of Health

A similar increase in presentations for children and young people aged 10 to 19 years was found in a New South Wales study of emergency departments presentations for mental health issues between 2010 and 2014. The study found that emergency department presentations relating to self-harm, intentional poisonings, or suicidal thoughts or behaviour had increased, on average, by 27 per cent each year.[400] This study noted that:

> … the rapid rise in presentations between 2010 and 2014 is likely to be multifactorial, with contributing elements including changes to family and peer relationships, onset of substance misuse (which often co-exists with mental health disorders) at younger ages, improved recognition of mental health problems, and the increasing prevalence of social media and smartphone technology. Recent reviews underscore the significance of social media for adolescent mental health, although definite causative associations have not been established. Nevertheless, it has been hypothesised that increased exposure to social media normalises self-harm, making teenagers vulnerable to peer pressure and cyber-bullying, as well as to low self-esteem, anxiety, depression, self-harm, and suicidal ideation.[401]

There were a total of 9,950 individual children and young people who attended an emergency department for self-harm or suicidal behaviours between 1 July 2009 and 30 June 2018. As shown in Figure 57, the number of first-time emergency department attendees has increased over the nine year period.

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[400] Perera et al, 'Presentations to NSW emergency departments with self-harm, suicidal ideation, or intentional poisoning, 2010-2014', *Medical Journal of Australia*, vol. 208, no. 8, April 2018, pp. 348-353, doi: 10.5694/mja17.00589.
[401] Perera et al, 'Presentations to NSW emergency departments with self-harm, suicidal ideation, or intentional poisoning, 2010-2014', *Medical Journal of Australia*, vol. 208, no. 8, April 2018, pp. 348-353, doi: 10.5694/mja17.00589.

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Figure 57: Individual children and young people who self-harmed and attended an emergency department, 2009-10 to 2017-18, by year of first attendance
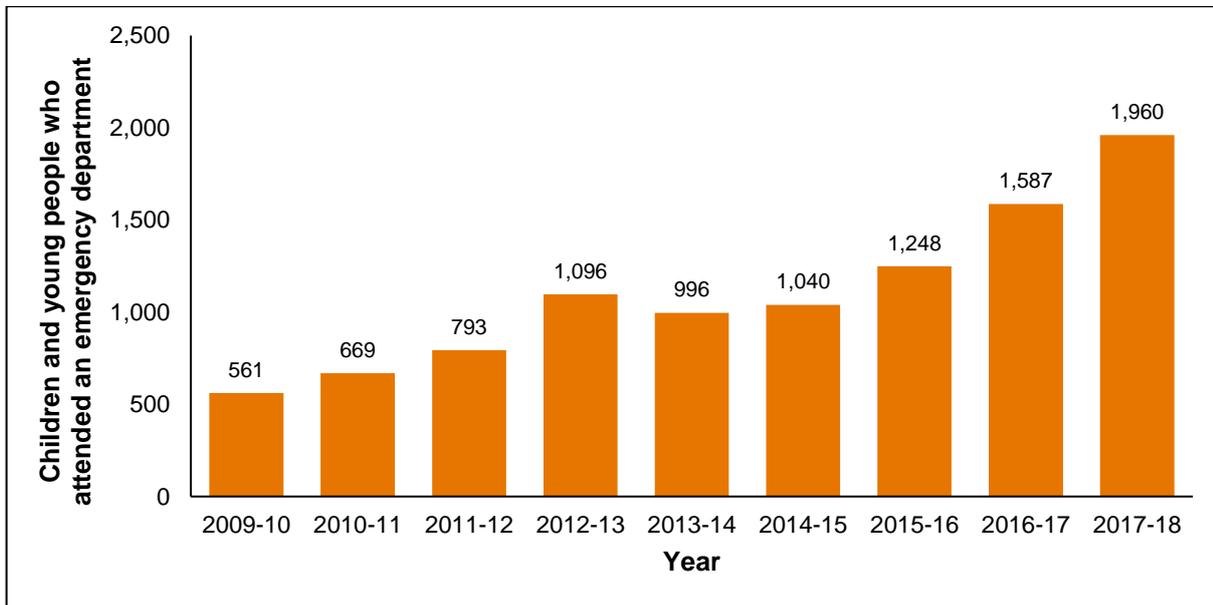
Source: Ombudsman Western Australia, Department of Health

4.5.3 Summary of self-harm related emergency department attendances by children and young people in Western Australia

Figure 58 sets out a summary of the circumstances of the emergency department presentations by Western Australian children and young people in relation to self-harm over 2009-10 to 2017-18.

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Figure 58: Summary of emergency department attendances, self-harm, by children and young people, Western Australia, 2009-10 to 2017-18

Emergency department attendances		
	Number of attendances	**Per cent**
	17,115	**100%**
Female patients	12,107	71%
Male patients	5,002	29%
Not recorded/stated	6	-
Day of the week		
Monday	2,932	17%
Tuesday	2,893	17%
Wednesday	2,792	16%
Thursday	2,701	16%
Friday	2,228	13%
Saturday	1,602	9%
Sunday	1,967	11%
Principal Diagnosis		
Acute stress reaction	4,064	24%
Personal history of self-harm	2,298	13%
Other specific neurotic disorders	1,800	11%
Depressive episode, unspecified	1,151	7%
Poisoning by 4-Aminophenol derivatives	676	4%
Other	8,126	42%
Duration of stay		
< one day	12,167	71%
One day	4,633	27%
Two days	206	.06%
Three or more days	109	1%
Discharge		
Departed under own care	11,925	70%
Admitted to ward	3,131	18%
Transferred	1,466	9%
Did not wait to be attended by medical officer/left at own risk	578	3%
Other/Unknown	15	0.1%

Source: Ombudsman Western Australia, Department of Health

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4.5.4 Characteristics of the children and young people who self-harmed and attended an emergency department

4.5.4.1 Age

The average age of children and young people who attended an emergency department for self-harm was 15 years. Similarly, most attendances (11,420) and most patients (6,583) were young people between the ages of 15 to 17 years of age.

The number of emergency department attendances for self-harm by 15 to 17 year olds has increased, from 533 in 2009-10 to 2,278 in 2017-18. However, emergency department attendances by children aged between 6 and 13 have also increased over the 9 year period, from a total of 148 attendances in 2009-10 to 617 in 2017-18.

Figure 59, below, sets out the Western Australian age-specific rates of children aged 6 to 13 years, young people 14 to 17 years and 16 to 17 years, who attended an emergency department for self-harm from 2009-10 to 2017-18 and had their age recorded (17,110 attendances).

Figure 59: Emergency department attendance rates, for the children and young people who self-harmed, Western Australia, 2009-10 to 2017-18, by age
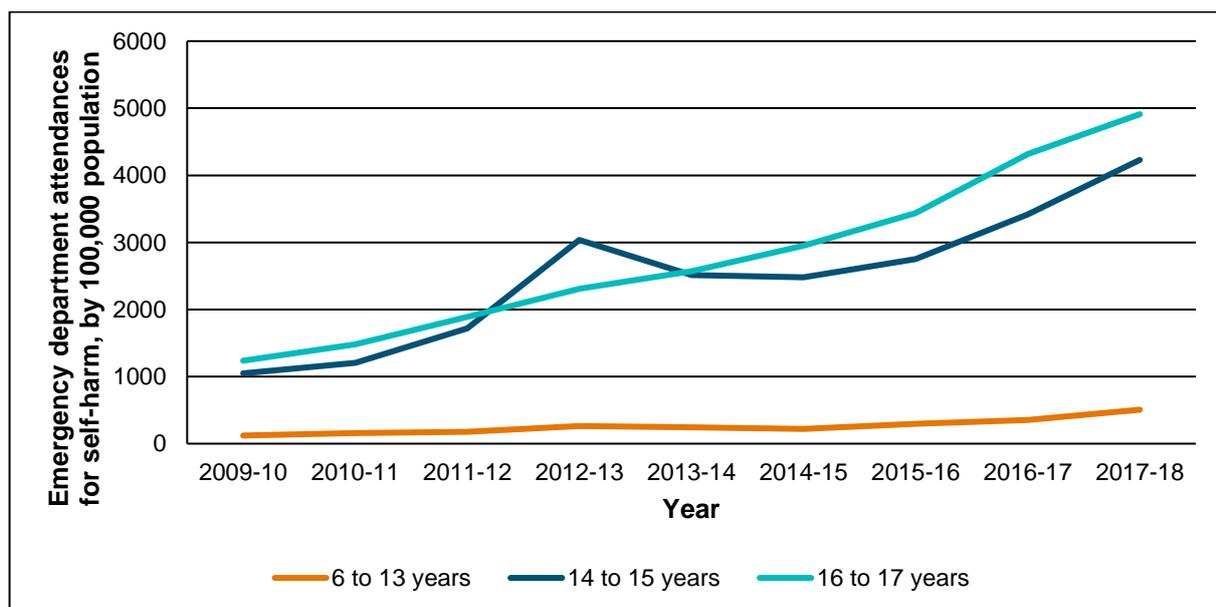
Source: Ombudsman Western Australia, Department of Health

The number of emergency department attendances increased for all ages between 2009-10 and 2017-18, except for 6 and 7 year old children including for:

- 10 year olds, which increased from seven attendances in 2009-10 to 41 in 2017-18;

- 11 year olds, which increased from nine attendances in 2009-10 to 67 in 2017-18; and

- 12 year olds increased from 29 attendances in 2009-10 to 151 in 2017-18.

Accordingly, Figure 60 shows that for the 17,109 emergency department attendances with an age recorded, there were increases in the number of attendances by children 6 to 13 years, from 148 in 2009-10 to 617 in 2017-18.

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Figure 60 also shows that emergency department attendances by young people 14 to 15 years increased from 315 in 2009-10 to 1,271 in 2017-18.

The largest increase in numbers of emergency department attendances for self-harm occurred within the 16 to 17 years old age group, which experienced an increase from 371 in 2009-10, to 1,473 in 2017-18.

Figure 60: Emergency department attendances for self-harm by children and young people, 2009-10 to 2017-18, by age
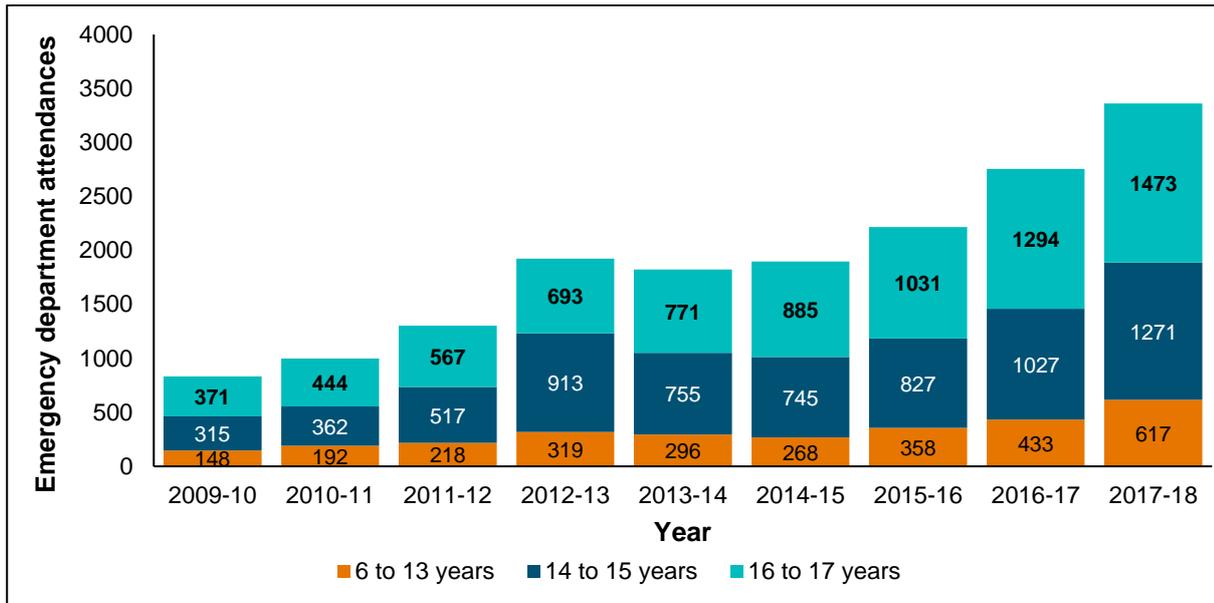
Source: Ombudsman Western Australia, Department of Health

4.5.4.2   Sex

Consistent with trends in the hospital admission of children and young people for self-harm and suicidal ideation and behaviour, female children and young people constituted most of the emergency department attendances. Of the 9,950 individual children and young people who attended an emergency department for self-harm, (9,946 of whom had their sex recorded):

- 6,532 (66 per cent) were female; and

- 3,414 (34 per cent) were male.

However, female children and young people did not attend emergency departments for self-harm at a higher rate across all ages.

As shown in Figure 61, emergency department attendances for self-harm among male children and young people have generally been lower over time compared to female children and young people, with increases observed in 2016-17 and 2017-18.

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Figure 61: Emergency department attendances for self-harm among children and young people, by sex and year
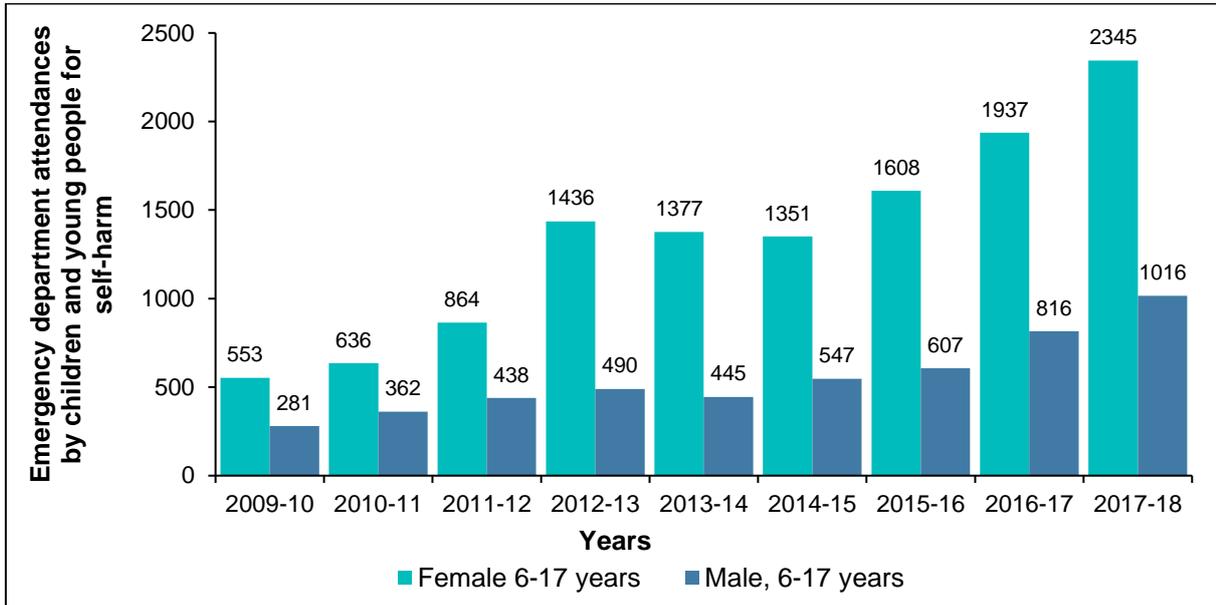
Source: Ombudsman Western Australia, Department of Health

As shown in Figure 62, both male and female young people 6 to 17 years attended emergency departments for treatment related to self-harm at an increased rate between 2009-10 and 2017-18.

Figure 62: Emergency department attendance rates for self-harm by children and young people, per 100,000, 6 to 17 years, 2009-10 to 2017-18, by sex and year

Source: Ombudsman Western Australia, Department of Health

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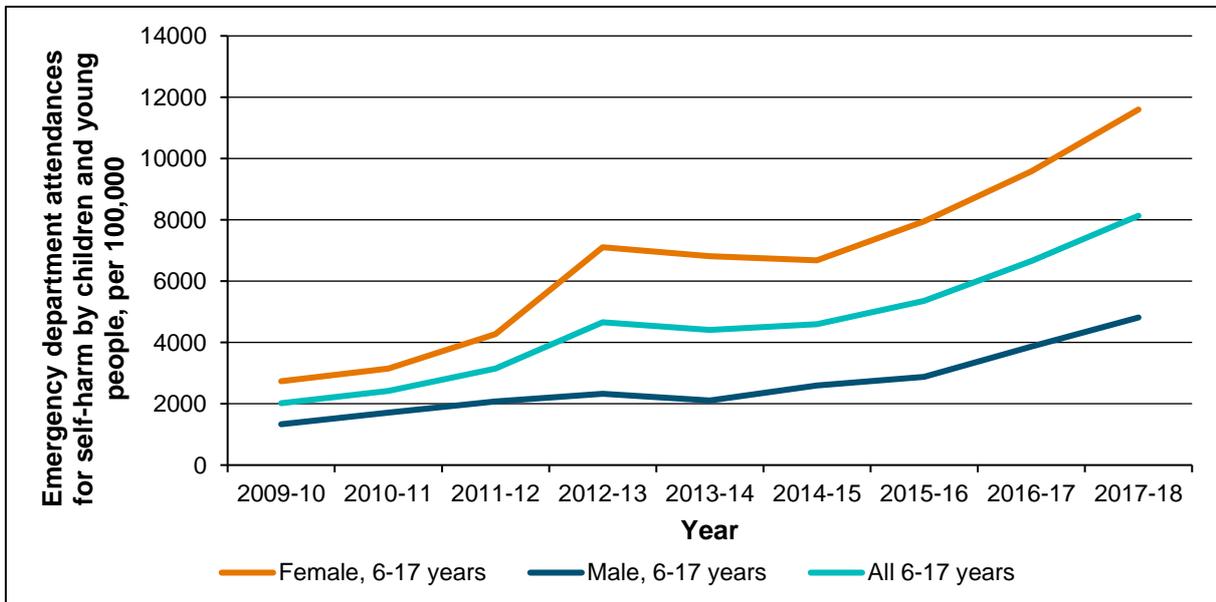
4.5.4.3   Age and sex

As shown in Figure 63, female children and young people did not attend emergency departments for self-harm at a higher rate across all ages. The Office's analysis indicates that:

- up until the age of 11, male children attended an emergency department at a higher rate than female children; and

- from the age of 12, the rate of emergency department attendances among female children and young people increased dramatically and exceeded the rate of emergency department attendances for self-harm by male children and young people at each age from 13 to 17.

Figure 63: Emergency department attendances for self-harm by children and young people, 2009-10 to 2017-18, by sex
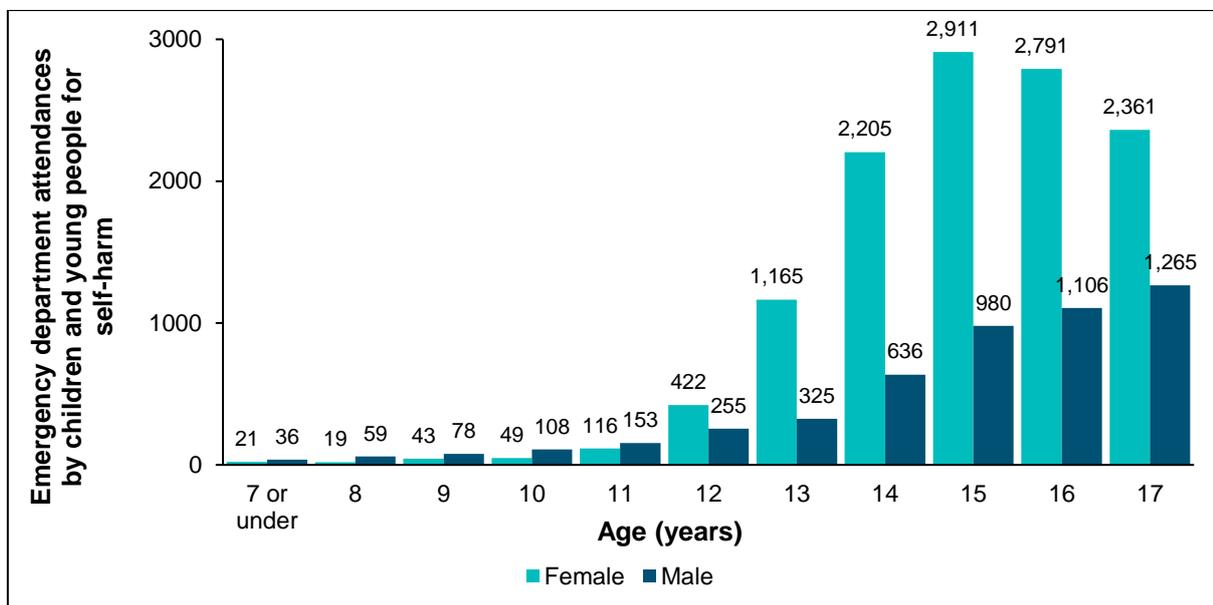
Source: Ombudsman Western Australia, Department of Health

4.5.4.4   Region of residence

As shown in Figure 64, emergency department attendances by children and young people who had self-harmed increased between 2009-10 and 2017-18 across the State, particularly in regional and remote areas. However, as noted previously, data for regional and remote emergency departments has only been captured completely from the start of the 2016-17 financial year.

In 2017-18, the majority of emergency department attendances for self-harm (of the 16,645 attendances with a residence recorded) resided in the Perth metropolitan area, as shown in Figure 64.

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Figure 64: Emergency department attendances with for self-harm among children and young people, by year and region of residence
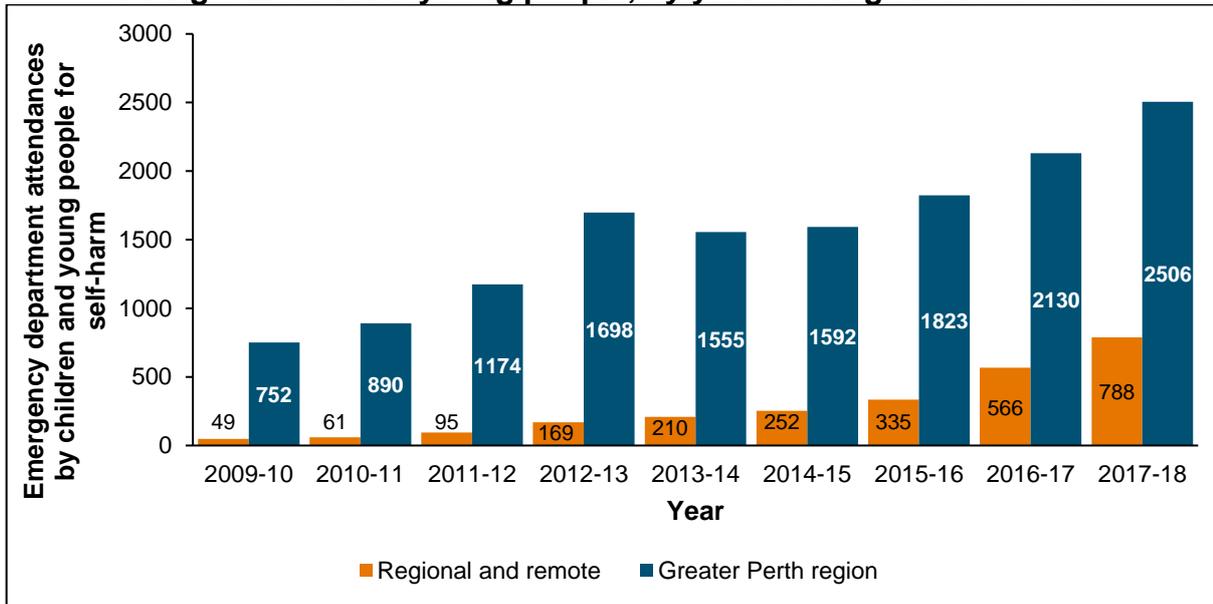
Source: Ombudsman Western Australia, Department of Health

However, children and young people from remote and very remote areas were overrepresented as compared to the 0 to 17 years population, despite data for the 2009 to 2016 period being incomplete for these areas.

Figure 65: Individual children and young people attending an emergency department for self-harm, by remoteness of residence at first attendance, Western Australia, 2017-18[402]
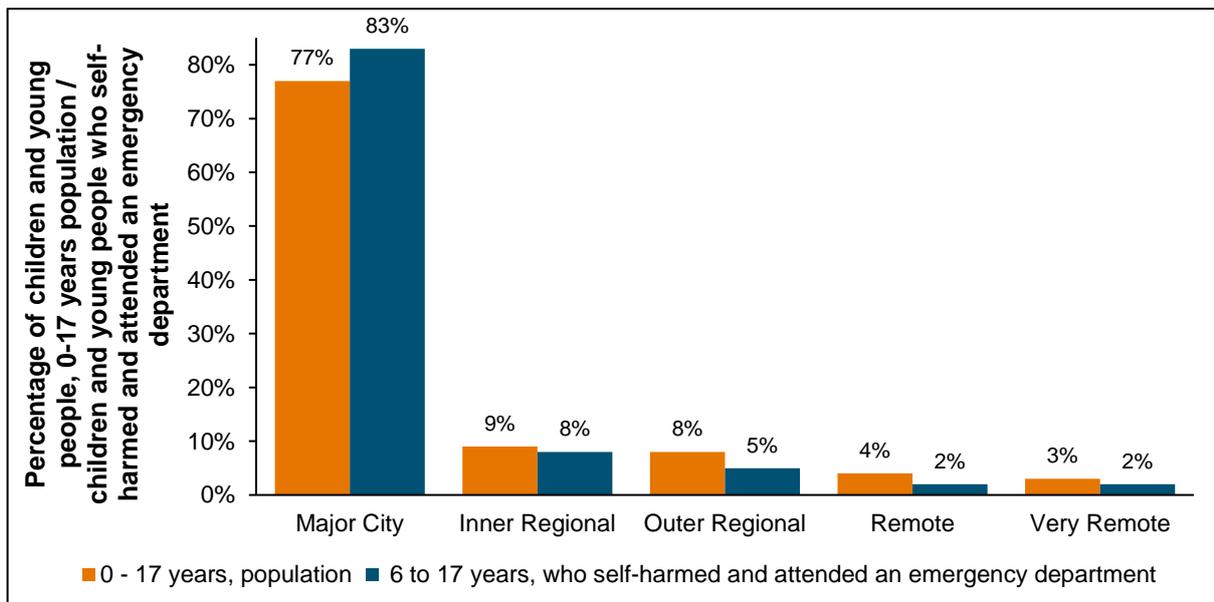
Source: Ombudsman Western Australia, Department of Health

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[402] To determine the population of children aged 0 to 17 in each 'Remoteness Area' the Office used a 2016 Census General Community Profile Remoteness Area for WA DataPack from the Australian Bureau of Statistics.

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4.5.4.5   Aboriginal and/or Torres Strait Islander children and young people

The number of emergency department attendances for self-harm by Aboriginal and/or Torres Strait Islander children and young people increased from 77 in 2009-10 to 399 in 2017-18.

In 2017-18, 14 per cent of the individual children and young people who attended an emergency department for self-harm were Aboriginal and/or Torres Strait Islander (from a total of 1,968 individual children and young people). By comparison, Aboriginal and/or Torres Strait Islander children and young people made up an estimated 7 per cent of the population of children and young people in Western Australia in June 2016.[403]

Figure 66 illustrates that the number of individual Aboriginal and/or Torres Strait Islander children and young people attending an emergency department each year increased over the investigation period, particularly in 2016-17 and 2017-18. However, as noted previously, data for regional and remote emergency departments has only been captured completely from the start of the 2016-17 financial year.

Figure 66: Individual children who self-harmed and attended an emergency department, by year and Aboriginal and/or Torres Strait Islander status
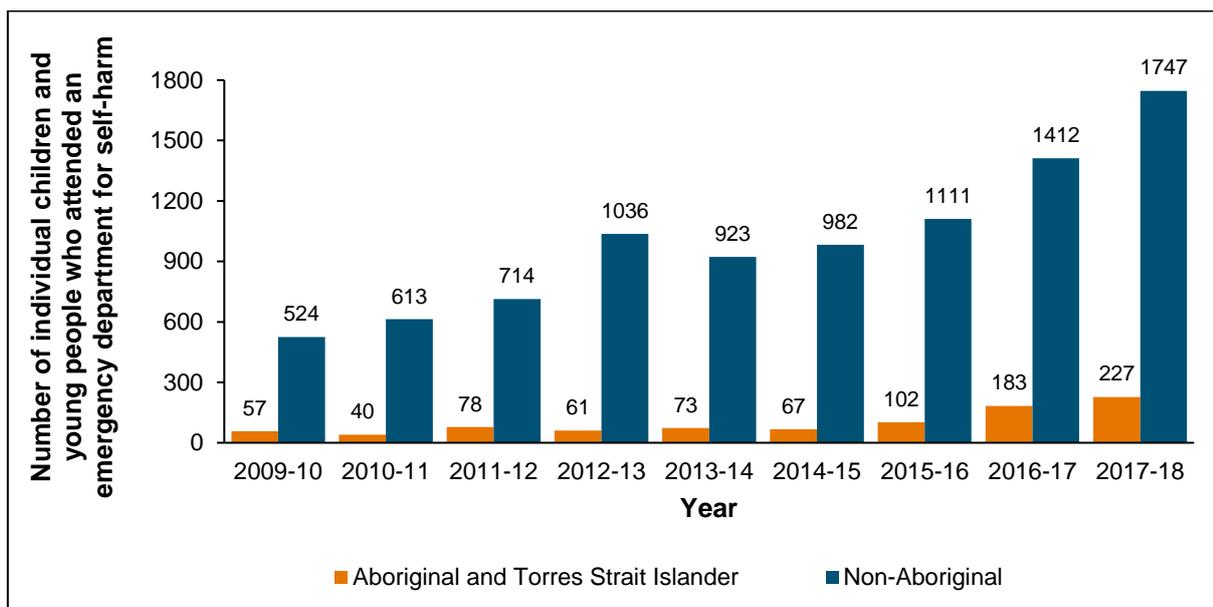
Source: Ombudsman Western Australia, Department of Health

4.5.4.6   Duration in emergency department

The majority of emergency department attendances by the 9,950 children and young people who self-harmed, were of less than one day's duration (71 per cent, 12,167 attendances).

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[403]   Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2018', *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.

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Figure 67: Emergency department attendances for self-harm among
children and young people, 2009-10 to 2017-18, by duration of stay
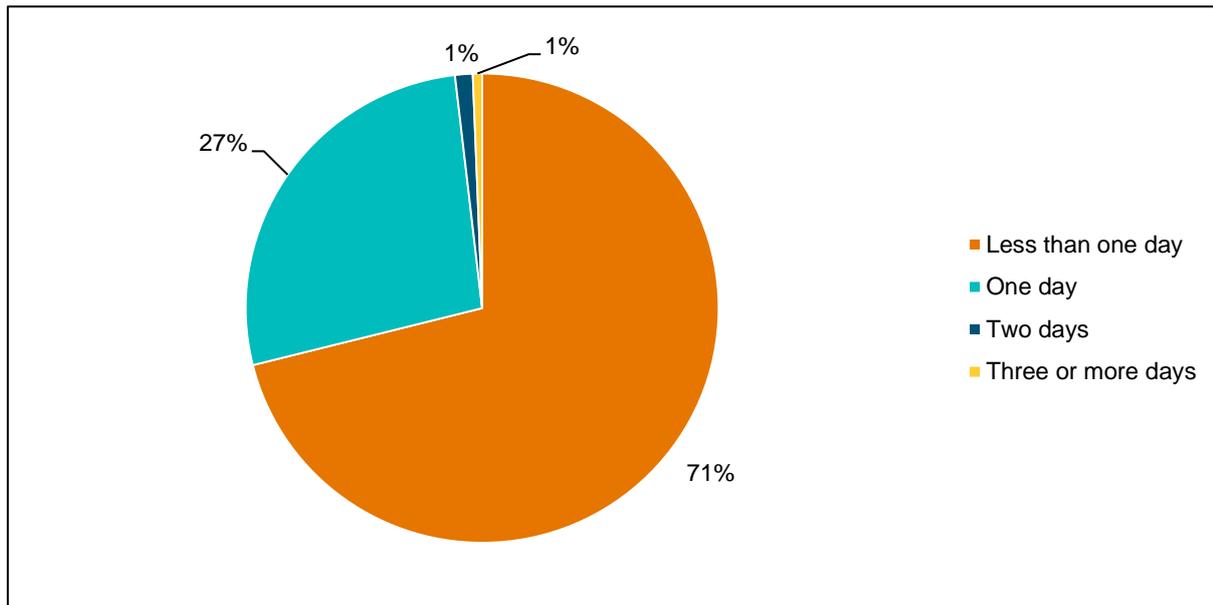
Source: Ombudsman Western Australia, Department of Health

4.5.4.7   Repeated emergency department attendances

The majority of the 9,950 children and young people attended an emergency department for self-harm only once between 2009-10 and 2017-18 (6,990 children and young people, 70 per cent).

Significantly, however, 289 children and young people attended an emergency department for treatment relating to self-harm on more than five occasions. This small proportion of children and young people (3 per cent) attended an emergency department on a combined 3,323 occasions (19 per cent).

Recommendation 2: That, further to Recommendation 1, the Mental Health Commission develop (as an adjunct to the State suicide prevention plan for children and young people) a separate suicide prevention plan for Aboriginal children and young people, given the special vulnerability and overrepresentation of Aboriginal children and young people in the number of deaths by suicide and hospital admissions and emergency department attendances for self-harm and suicidal behaviour.

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5. Opportunities to improve data collection on the patterns and trends in suicide and self-harm by children and young people

As discussed earlier in Chapter 3.1 of this volume, the research literature identifies the importance of timely, accurate and accessible surveillance data on suicide and suicide attempts as a fundamental requirement for planning, implementing and evaluating a comprehensive suicide prevention response.

Although not all children and young people who die by suicide will necessarily have self-harmed prior to their death, improving data collection, and the use of data, on suicide, suicide attempts, self-harm and factors associated with suicide experienced by children and young people is essential for:

- enhancing our understanding of vulnerable children, young people and communities; and

- evaluating the effectiveness of suicide prevention, mental health promotion, and drug and alcohol treatment activities.

Drawing from the research literature and our analysis of the data on suicide and self-harm by children and young people in Western Australia from 1 July 2009 to 30 June 2018, the Office has identified three potential areas for improvement in data collection:

1. Identification of children and young people as Aboriginal and/or Torres Strait Islander;

2. Timeliness and publication of data on suicide, suicide attempts and self-harm by children and young people; and

3. Suicide, self-harm and mental ill-health in lesbian, gay, bisexual, trans and gender diverse, queer and intersex (**LGBTQI+**) children and young people.

5.1 Improving data collection on the identification of children and young people as Aboriginal and/or Torres Strait Islander

5.1.1 Research literature

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (**ATSISPEP**) *Real Time Suicide Data: A Discussion Paper* identifies the 'variable quality of Aboriginal and Torres Strait Islander identification at the State and national levels, resulting in an unexpected under-reporting'[404] of Aboriginal and Torres Strait Islander people who died by suicide. Relevantly, this paper also notes that:

> It is estimated that thousands of Indigenous Australians, alongside those of CALD backgrounds, have not had their birth registered, or do not have sufficient levels of identification to enable issuing of a birth certificate. This is not restricted to members of the Stolen Generation who may have had

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[404] Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 2.

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arbitrary dates of birth assigned to them on a mission, but also for many children born currently. …

Even though the question of cultural identity is a mandatory question for police attending deaths, there is little quality control to ensure that the question is asked. It is possible that police attending a suspected suicide may feel that asking too many apparently administrative questions furthers the distress of the relatives present. In an effort to improve identification, Victoria has introduced a process where Funeral Directors are required to ask 'the question: "Was the deceased of Aboriginal or Torres Strait Islander origin?" of every informant and/or the person who knew the deceased when completing a Death Registration Statement.

The ATSISPEP Data and Statistics Roundtable Consultation recommended that questions of cultural identity always be asked of the senior next of kin, and that appropriate education be provided to everyone asking the question to ensure that it is managed in a culturally safe manner.[405]

In Western Australia, a 2016 study that examined factors associated with birth registration for babies born to Aboriginal mothers from 1980 to 2010 identified that:

Almost one-in-five children with Aboriginal mothers born in Western Australia from 1996 to 2010 did not have a birth registration record by 2012. Unregistered children were significantly more likely to have mothers who were teenagers when they had their first child, who lived in remote and very remote areas, who did not have private hospital insurance and whose own births were not registered. There is evidence that registration rates have increased in regional and remote areas in recent years. …

In its current form, the birth registration system does not adequately help the most disadvantaged become registered, so changes are necessary in order to increase Aboriginal birth registration rates. In the short term, as almost all births take place in hospital in WA, assistance completing the birth registration form before the mother and child leave the hospital may increase registration, in addition to expanded catch-up registration programs. This assistance could be particularly targeted towards providing additional support to mothers who are teenagers, which may in turn increase the prospects of registration for their subsequent births.

In the longer term, more fundamental changes to the current birth registration system may be required in order to increase the birth registration rates of children of Aboriginal mothers towards that of the non-Aboriginal population in Western Australia. Some states and territories (e.g. Northern Territory) have much lower rates of delayed birth registration than Western Australia, suggesting their systems have fewer barriers to birth registration.

Western Australia's data linkage system routinely links birth registrations and the Midwives Notification System, providing a simple mechanism for tracking

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[405] Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 3.

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progress towards the goal of universal birth registration for Aboriginal children.[406]

More recently, the Department of Justice's *Annual Report 2017/18* notes that the merger of the former Departments of the Attorney General and Corrective Services has enhanced service provision in regional and remote areas through:

> … greater synergies across the courts and corrective services functions … [including] by creating opportunities at Courts, in Corrective Services and out in remote communities, to better assist people to obtain their personal identification documentation produced by the Registry of Births, Deaths and Marriages.[407]

The Registry of Births, Deaths and Marriages has also taken steps to improve rates of birth registration for 'disadvantaged or vulnerable people living in regional and remote Aboriginal communities'[408] through its involvement in the Department of Justice's 'Open Day Program':

> Since the Registry's involvement with the Open Day Program in 2011/12, the Registry has issued more than 4,230 birth certificates, registered 1,573 previously unregistered Aboriginal births and issued more than 2,065 confirmation of birth letters.

> Of the 1,573 previously unregistered births 268 relate to births pre-1980. Approximately 18 per cent of births registered through the Open Day Program relate to births that occurred more than 30 years ago. During the financial year the Registry issued more than 617 birth certificates, registered 155 previously unregistered births and issued over 155 confirmation of birth letters.[409]

5.1.2 The 2020 investigation

During the 2020 investigation, the Office considered child death review notifications received by the Ombudsman and identified that a significant proportion of the child death notifications received each year state that a child or young person's Aboriginal or Torres Strait Islander status is 'unknown', as shown in the Ombudsman Western Australia *Annual Report 2018-19* and in Figure 68:

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[406] Gibberd AL, Simpson JM, and Eades SJ, 'No official identity: a data linkage study of birth registration of Aboriginal children in Western Australia', *Australian and New Zealand Journal of Public Health*, vol. 40, no. 4, August 2016, pp. 388-394.
[407] Department of Justice, *Annual Report 2017/18*, viewed 21 March 2019, <https://department.justice.wa.gov.au/_files/annual-reports/DoJ-Annual-Report-2017-2018.pdf>, pp. 4, 35.
[408] Department of Justice, *Annual Report 2017/18*, viewed 21 March 2019, <https://department.justice.wa.gov.au/_files/annual-reports/DoJ-Annual-Report-2017-2018.pdf>, pp. 4, 35.
[409] Department of Justice, *Annual Report 2017/18*, viewed 21 March 2019, <https://department.justice.wa.gov.au/_files/annual-reports/DoJ-Annual-Report-2017-2018.pdf>, pp. 4, 35.

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Figure 68: Number of child death review notifications received, 2009-10 to 2018-19, by year and recorded Aboriginal and Torres Strait Islander status

Year	Aboriginal and/or Torres Strait Islander	Non-Aboriginal	Unknown	Total Notifications	Percentage of notifications received with 'unknown' Aboriginal status
2009-10	18	38	20	76	26%
2010-11	24	61	33	118	28%
2011-12	25	35	23	83	28%
2012-13	26	31	49	106	46%
2013-14	16	20	34	70	49%
2014-15	20	32	32	84	38%
2015-16	21	39	24	84	29%
2016-17	26	43	20	89	22%
2017-18	18	29	26	73	36%
2018-19	18	23	37	78	47%

Source: Ombudsman Western Australia

The Office also observed inconsistencies in the recording of Aboriginal and Torres Strait Islander identity of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide. These inconsistencies occurred:

- between State government departments and authorities;

- within the records of individual agencies;

- during children and young people's lives; and

- after their deaths by suicide.

As discussed in detail in Chapter 6 of this volume, connection to culture, country and community is essential to the wellbeing of Aboriginal and Torres Strait Islander children and young people. The research literature[410] and previous reports and inquiries[411] regarding suicide prevention for Aboriginal and Torres Strait Islander people emphasise the importance of providing culturally informed services and care to Aboriginal children and young people at risk. The first step in providing culturally appropriate services to Aboriginal and Torres Strait Islander children and young people is asking questions of

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[410] Dudgeon P, et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 12, citing Chandler MJ and Lalond, CE, 'Cultural continuity as a protective factor against suicide in First Nations youth', Horizons – A Special Issue on Aboriginal Youth, Hope or Heartbreak: Aboriginal Youth and Canada's Future, vol. 10, no. 1, 2008, pp. 68-72.
[411] Gordon, S, Hallahan, K, and Henry D, Putting the picture together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, Department of Premier and Cabinet, Perth, 2002, p. 360.-361; Coroner's Court of Western Australia, Inquest into the deaths of: Thirteen children and young persons in the Kimberley region, Western Australia, 2019, pp. 8-9.

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cultural identity,[412] and understanding the community's 'language, traditions and customs and family and community obligations'.[413]

Accordingly, it is important for State government departments and authorities to work collaboratively in sharing and recording the Aboriginal and Torres Strait Islander status of children and young people.

Recommendation 3: That the Mental Health Commission, Department of Health, Department of Communities and Department of Education:

- work collaboratively with each other and Aboriginal and Torres Strait Islander people to identify culturally safe ways to ask questions about cultural identity in situations where there are concerns about a child or young person's self-harming or suicidal behaviour; and

- proactively share this information when multiple agencies are working with a child, young person, or their family, in order to provide culturally informed services and care.

5.2 Improving the timeliness and publication of data on suicide, suicide attempts and self-harm by children and young people

Orygen's report *Looking the other way: young people and self-harm* and the National Child's Commissioner's *Children's Right Report* both identify that the lack of data collection and monitoring in relation to suicide and self-harm by children and young people is:

> … a significant obstacle to effective research and an ongoing barrier to building an evidence base upon which to build policy and program responses for suicide and self-harm in children and young people.[414]

ATSISPEP's *Real Time Suicide Data: A Discussion Paper* also relevantly identifies the value of timely suicide, suicide attempt and self-harm data:

> It is also imperative that policies aimed at preventing suicide are developed based on good quality information and evidence. The design and implementation of effective preventive measures will be greatly enhanced by timely information on the characteristics of those who have suicided and the identification of possible current causative influences in specific populations in each state and territory.

> There is no doubt that work to improve the speed of availability of data, and its quality is being actively pursued locally and internationally. One can't underestimate this effort – if timely knowledge of a suicide saves just one further life, its value cannot be denied.

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[412] Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 3.

[413] Gordon, S, Hallahan, K, and Henry D, Putting the picture together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, Department of Premier and Cabinet, Perth, 2002, p. 360.

[414] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 14, citing Australian Human Rights Commission, *Children's Rights Report*, Australian Human Rights Commission, Sydney, 2014, p. 62.

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It may be that the most beneficial mechanism to establish best practice will be to combine different approaches. The positive potential of the use of social media as a monitoring tool could be combined with the comprehensive data collection being established by the WACSIS.[415]

Orygen recommends improving data collection on suicide and self-harming behaviours in children and young people could be achieved by:

> … 1) taking the sentinel data collection system currently operating in Newcastle and replicating it in other sites, 2) by including questions relating to self-harm in relevant population-based health surveys and 3) ensuring the ATAPS minimum data set captures self-harm related information including: principal diagnosis, treatment duration and outcomes.[416]

The 'sentinel data collection system' operating in Newcastle is the Hunter Area Toxicology Service and was also considered by the recent Parliament of New South Wales Joint Committee on Children and Young People Inquiry into *Prevention of Youth Suicide in New South Wales Final Report*, which noted that:

> The Hunter Area Toxicology Service (HATS) was first established in 1986 and currently operates out of the Calvary Mater Hospital, Newcastle. The purpose of the service is to assess and admit patients who present with self-poisoning. The service also administers a database to record self-poisonings and related patient information such as gender, marital status, length of stay and psychiatric history.

> HATS is Australia's only established sentinel data system. Similar poisons databases in England, Scotland, Wales, the USA and Norway have been modelled on the HATS database. …

> Although there is a complex relationship between self-harm and suicide, the Committee acknowledges that there is evidence of a link. While any self-harm is a cause for concern, this link between suicide and self-harm makes the Committee especially troubled by the reported increase in self-harm among children and young people, particularly teenage girls. …

> A multicentre sentinel system would be a more permanent and systematic way of collecting reliable data on self-harm and suicide attempts. Having accurate and reliable statistics on self-harm in the New South Wales population, particularly children and young people, is crucial to understanding trends and identifying emerging clusters and early intervention strategies.

> The Committee suggests that the proposed multicentre sentinel system could be influenced by the model established in the UK, particularly in how it is designed to reflect a representative sample of the population. This hospital-based system should also be informed by the design and experiences of HATS in Newcastle.

> To form a more accurate picture of the prevalence of self-harm in the community, the Committee also believes that the ideal model should collect

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[415] Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 8.
[416] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

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data from emergency departments, hospital admissions and a range of other sources like general practitioners, as well as ambulance officers and police who may attend a self-harm incident.[417]

The Office notes the pleasing progress that has been made in recent years by the Department of Health in capturing self-harm hospital attendances and admissions data in relation to children and young people, particularly in regional areas, however also acknowledges the gaps that exist in our population level self-harm data. Continuous improvement of self-harm data collection and monitoring systems in hospital 'will lead to better care for people who have self-harmed, while linking to research databases would then enable the impact of policy, program and clinical interventions to be better tracked, compared and reported over time.'[418]

Recommendation 4: That the Mental Health Commission and the Department of Health working collaboratively:
- investigate the feasibility of developing a linked sentinel data collection system recording the prevalence of, and characteristics associated with, self-harm by children and young people; and
- consider selecting a number of hospitals in Western Australia representative of Western Australia's population demographics, building on both the Newcastle model and United Kingdom multicentre study cited in Orygen's *Looking the other way: young people and self-harm* report.

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[417] Joint Committee on Children and Young People, *Prevention of Youth Suicide in New South Wales, Report 5/56*, Parliament of New South Wales, Sydney, October 2018, pp. 63-65.
[418] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 14.

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5.3 Improving data collection on suicide, self-harm and mental illness in LGBTQI+ children and young people

As identified in Chapters 3.5.8 and 5.1 of this volume, LGBTQI+ communities across the world are a vulnerable group with higher rates of suicide.[419] A 2015 study conducted by the Australian Institute for Suicide Research and Prevention for *beyond blue* identified that:

> The results [from their comparative study] paint a picture of a great deal of emotion, conflict, and distress in the lives of those LGBT individuals that died by suicide. Younger suicides were characterised principally by non-acceptance (by family but also by self). …

> In summary, the key factors found to relate to suicide in LGBT people from the study are a lack of acceptance by family and self, a high incidence of romantic relationship conflict and aggressive behaviours, and a greater prevalence of depression and anxiety and alcohol and substance use disorders. The findings suggest that LGBT people may require targeted approaches in mental health services, including relationship and family counselling, school based programs, and public health and stigma reduction campaigns, particularly around supporting full and healthy development of an LGBT identity and the provision of culturally appropriate and accessible services. The need for services to be inclusive of sexuality and gender diversity is highlighted by the apparent missed opportunities for engagement and intervention with LGBT individuals who died [by] suicide ([who had significantly] more frequent treatment with medication and by a psychiatrist [than living controls]).[420]

The Telethon Kids Institute's 2017 report *Trans Pathways: the mental health experiences and care pathways of trans young people* also identified that rates 'of self-harm and suicidality were extremely high' in the trans young people aged 14 to 25 years surveyed with 79.7% of participants ever self-harming and 48.1% ever attempting suicide'.[421]

However, a significant gap in the evidence base exists in relation to the data for suicide, suicide attempts and self-harm children and young people who identify as same-sex attracted or gender diverse in Western Australia.

5.3.1.1 *In some jurisdictions, government guidelines provide guidance as to the collection of sex, gender, and sexual orientation data*

Since 2013, the *Australian Government Guidelines on the Recognition of Sex and Gender* have required Commonwealth Government departments and agencies to consistently

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[419] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014,
p. 37.
[420] Skerett DM, Kõlves K, and De Leo D, Suicidal behaviours in LGBT populations: Final Report to the beyondblue, Australian Institute for Suicide Research and Prevention, 2015, pp. 4 and 6.
[421] Strauss P et al, 'Summary of results', *Trans Pathways: the mental health experiences and care pathways of trans young people*, Telethon Kids Institute, Perth, Australia, 2017, p. 34.

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collect, use and amend 'sex and gender information held in individual personal records.'[422] These Guidelines relevantly recognise that:

> A person's sex and gender may not necessarily be the same. Some people may identify as a different gender to their birth sex and some people may identify as neither exclusively male nor female.

> The preferred Australian Government approach is to collect and use gender information. Information regarding sex would ordinarily not be required and should only be collected where there is a legitimate need for that information and it is consistent with Australian Privacy Principle 3 … Individuals may have biological characteristics or undergo a variety of treatments that make it difficult to identify or define a person's true biological sex. Sex can also be legally changed in Australian identity documents, including birth certificates.

> The necessity of a medical service or associated benefit should be determined by the physical need for that service or benefit, regardless of a person's recorded sex and/or gender.

> Departments and agencies should ensure when they collect sex and/or gender information they use the correct terminology for the information they are seeking.[423]

In the United Kingdom, the Government Equalities Office report LGBT Action Plan: improving the lives of lesbian, gay, bisexual and transgender people identifies that:

> Being LGBT makes a difference to your health and wellbeing, your likelihood to be a victim of certain kinds of crime, and your education. Good public services are designed with data, but many services do not routinely monitor sexual orientation or gender identity. Those parts of government that do monitor these protected characteristics do not do so consistently. Sexual orientation and gender identity monitoring can help public service providers to better understand and cater for the needs of people who are LGBT, as well as people who are not. Better data leads to better services. …

> We will enable government services to appropriately monitor sexual orientation and gender identity. …

> We will ensure the Civil Service is an exemplar employer for collecting data on sexual orientation and gender identity in a sensitive, respectful and proportionate way. …

> We will provide guidance on protecting private data concerning the characteristics and history of transgender people. …

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[422] Australian Government, *Australian Government Guidelines on the Recognition of Sex and Gender*, November 2015,
viewed 26 October 2019, <https://www.ag.gov.au/Publications/Documents/AustralianGovernmentGuidelinesontheRe cognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.pdf>, p. 3.
[423] Attorney-General's Department, *Australian Government Guidelines on the Recognition of Sex and Gender*, Australian
Government, November 2015, viewed 26 October 2019, <https://www.ag.gov.au/Publications/Documents/Australian GovernmentGuidelinesontheRecognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexa ndGender.pdf>, p 4.

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We will undertake further work to improve our understanding of the needs of specific groups within the LGBT population. …[424]

5.3.1.2 Collecting non-binary sex and gender data or and sexual orientation data where it is appropriate to do so

Through the work undertaken as part of the 2020 Investigation, the Office identified that State government departments and authorities, including the Department of Communities and Department of Health, record different sets of data relating to sex and gender, as summarised in Figure 69:

Figure 69: Summary of data recorded relating to sex and gender

	Department of Health	**Department of Communities**
Does the department or authority record sex or gender?	Biological sex data is recorded in the Emergency Department Data Collection.[425] 'Gender' is recorded in the TOPAS, HCARe and webPAS systems however, is defined as biological sex. Gender identity data is not captured.	Gender
Is sex or gender data captured in a non-binary format?	Sex data is captured in a non-binary format, as: • male, female or indeterminate in TOPAS, HCARe and webPAS;[426] and • male, female, 'intersex or indeterminate, or; not stated/inadequately described' in the Emergency Department Data Collection.[427]	No: Binary
Are there any relevant legislative or policy considerations relating to the recording of data on sex and gender?	Binding Information Management Policy Framework issued by the Director General under section 26 of the *Health Services Act 2016*[428]	None publicly available

Source: Ombudsman Western Australia

The *Victorian Family Violence Data Collection Framework* contains guidelines for collecting data relating to family violence experienced by LGBTIQ+ communities and states that:

> ... organisational change and staff training relating to LGBTI inclusive practice is vital … It is important to avoid making assumptions about a person's gender identity, sex, sexual orientation or intersex variation. Without educating staff,

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[424] Government Equalities Office, *LGBT Action Plan*: *Improving the lives of lesbian, gay, bisexual and transgender people*,
July 2018, viewed 21 March 2019, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721367/GEO-LGBT-Action-Plan.pdf>, pp 23-24.

[425] Department of Health, Operational Directive: Emergency department and emergency services patient-level data collection and recording, ED0205/09, 7 July 2009, p. 7; Department of Health, Hospital Morbidity Data System: Reference Manual Part A: Contacts, Hospital Responsibilities, Data Element Definitions, V1.0, July 2017.

[426] Department of Health, *Hospital Morbidity Data System: HMDS Reference Manual*, Government of Western Australia, Perth, 2015, pp. 159-160.

[427] Department of Health, *Emergency Department Data Collection Data Dictionary*, Government of Western Australia, Perth, 2007, pp. 104-105.

[428] Department of Health, *Information Management, Version 10*, 18 October 2018.

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> there is a risk of misgendering or incorrectly interpreting a … situation, and causing harm to clients. Staff need to be trained in recognising when it may not be appropriate to ask, and in how to sensitively and respectfully collect data.
>
> … it is worth noting again the importance of confidentiality, and how this specifically relates to LGBTI communities. As stated in the Rainbow Tick guide to LGBTI-inclusive practice, "disclosure has the potential to significantly impact on an LGBTI person's safety, health and wellbeing and their social connectedness ... this may create real tensions for the LGBTI consumer regarding confidentiality and unintended disclosure". If someone does not wish to disclose information, that is their choice and it should be respected. [citation omitted][429]

Further, the *Victorian Family Violence Data Collection Framework* notes that sexual orientation data should only be collected in circumstances where:

- agencies are 'aware of and understand the needs of diverse LGBTI communities so that they may collect information appropriately, and provide an appropriate response';[430]

- people are willing to disclose;[431]

- the information can be collected and stored sensitivity, bearing in mind privacy implications and relevant legislative requirements;[432] and

- there is a clear link to 'a direct service response or referral to an appropriate service'.[433]

Accordingly, there is an opportunity to enhance our understanding of suicide and self-harm by LGBTIQ+ children and young people in Western Australia by improving the consistency of the recording of relevant gender and sexual identity data by the Department of Health and Department of Communities.

Recommendation 5:
- That the Department of Health and Department of Communities should collect gender data in a non-binary form when this is provided with a child or young person's consent and would not offend, 'out', or otherwise inappropriately disclose a child or young person's gender identity.
- That the Department of Health and Department of Communities should record information about a child or young person's sexual identity where this is provided with the child or young person's consent, is relevant to their suicidal or self-harming behaviour, and does not offend, 'out', or otherwise inappropriately disclose a child or young person's sexual identity.

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[429] Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

[430] Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 54.

[431] Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 54.

[432] Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 56.

[433] Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

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6. Aboriginal and/or Torres Strait Islander children and young people who died by suicide

6.1 Historical context

Aboriginal and Torres Strait Islander peoples are the oldest continuous living cultures on the planet, having lived in Australia for at least 65,000 years.[434] Prior to 1788, there were more than 250 distinct languages and countless dialects spoken throughout Australia,[435] with an estimated population of between 750,000 to 1,000,000 people.[436] This pre-colonial population was made up of many diverse Aboriginal and Torres Strait Islander communities, each with their own complex sets of cultural beliefs and practices, laws, family and kinship systems, land ownership structures, arts and traditions.[437]

Aboriginal and Torres Strait Islander culture is a significant protective force and strength for children and young people. There is a wealth of evidence demonstrating a positive correlation between health, education, wellbeing, employment outcomes, family functioning and safety for children and communities, with language and culture.[438]

However, as observed in the *Bringing them home* report, the British 'invasion'[439] of Australia brought very rapid changes to Aboriginal and Torres Strait Islander societies and widespread forcible removal of Aboriginal children from their families, where these children were commoditised and viewed by Europeans primarily as a source of labour:

> Violent battles over rights to land, food and water sources characterised race relations in the nineteenth century. Throughout this conflict Indigenous children were kidnapped and exploited for their labour. Indigenous children were still being 'run down' by Europeans in the northern areas of Australia in the early twentieth century.
>
> … the greatest advantage of young Aboriginal servants was that they came cheap and were never paid beyond the provision of variable quantities of food and clothing. As a result any European on or near the frontier, quite regardless of their own circumstances, could acquire and maintain a personal servant […].

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[434] Clarkson C et al, 'Human occupation of northern Australia by 65,000 years ago', *Nature*, vol. 547, no. 7663, pp. 306-310, doi: 10.1038/nature22968.

[435] Walsh M, 'Languages and their status in Aboriginal Australia', in Walsh M and Yallop C, *Language and Culture in Aboriginal Australia*, Aboriginal Studies Press, 1993.

[436] Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander Population' *Year Book Australia, 2008,* cat. no. 1301.0, ABS, Canberra, February 2008.

[437] Bourke E, 'The first Australians: Kinship, family and identity', *Family Matters*, vol. 85, August 1993, viewed 6 May 2019, <https://aifs.gov.au/publications/family-matters/issue-35/first-australians-kinship-family-and-identity>.

[438] Lohoar S, Butera N, and Kennedy E, Strengths of Australian Aboriginal cultural practices in family life and child rearing: Child and Family Community Australia Paper No. 25, Australian Institute of Family Studies, September 2014, viewed 21 March 2019, <https://aifs.gov.au/cfca/publications/strengths-australian-aboriginal-cultural-practices-fam/export>; House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, Commonwealth of Australia, Our Land Our Languages: Language Learning in Indigenous Communities, Canberra, September 201; Lawrence R, Research on strong Indigenous communities, Brief 1, Indigenous Justice Clearinghouse, April 2007, viewed 21 March 2019, <https://www.indigenousjustice.gov.au/wp-content/uploads/mp/files/publications/files/brief001.pdf>.

[439] Australian Government Human Rights and Equal Opportunity Commission, Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 38.

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Governments and missionaries also targeted Indigenous children for removal from their families. Their motives were to 'inculcate European values and work habits in children, who would then be employed in service to the colonial settlers.' In 1814 Governor Macquarie funded the first school for Aboriginal children. Its novelty was an initial attraction for Indigenous families but within a few years it evoked a hostile response when it became apparent that its purpose was to distance the children from their families and communities.

… The violence and disease associated with colonialism was characterized, in the language of social Darwinism, as a natural process of 'survival of the fittest'. Accordingly to this analysis, the future of Aboriginal people was inevitably doomed and what was needed from governments and missionaries was to 'smooth the dying pillow.' [citations omitted][440]

In Western Australia, Aboriginal children were removed from their mothers when they were about 4 years old, placed in dormitories, and then, at about 14 years old, sent to missions and settlements to work, under legislative powers granted to the 'Chief Protector'[441]:

The *Aborigines Act* [1905] established an administrative regime under the control of a 'Chief Protector' that covered every aspect of Aboriginal peoples' lives. The Aborigines Act assumes that Aboriginal peoples were a 'dying race' in its objective of forced assimilation of future generations.

The subsequent *Native Administration Act 1936* (WA) provided the 'Chief Protector' with total control of all Aboriginal children aged twenty-one years and under, including the legal right to remove … children from their families and place them in institutions, or to allow their adoption by non-Aboriginal families. The *Native Administration Act* consequently impacted Aboriginal peoples' enduring connection to country, family and community and their right to continue to practice and pass on their language and culture to future generations, resulting in its suppression and loss.

Administration of the *Aborigines Act* and the *Native Administration Act* fell to the WA Native Welfare Department. This department was only abolished in 1972 …[442]

From approximately 1910 to 1970 'not one Indigenous family … escaped the effects of forcible removal,'[443] and the ongoing legacy of these laws, policies and practices on Aboriginal peoples has created intergenerational trauma:

If people don't have an opportunity to heal from trauma, it continues to impact on the way they think and behave, which can lead to a range of negative

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[440] Australian Government Human Rights and Equal Opportunity Commission, Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 23.

[441] Australian Government Human Rights and Equal Opportunity Commission, Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 25.

[442] Department for Child Protection and Family Support, *Aboriginal Services and Practice Framework 2016-2018*, 2016,
viewed 21 March2019, <https://www.dcp.wa.gov.au/Resources/Documents/ABORIGINAL%20SERVICES%20AND%20PRACTICE%20FRAMEWORK.pdf>, p. 4.

[443] Australian Government Human Rights and Equal Opportunity Commission, Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 31.

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outcomes including poor health, violence and substance abuse. This in turn leads to a vicious cycle of social and economic disadvantage.

Unknowingly, the trauma is often passed down to the next generation and then the next, which creates a ripple effect within families and communities. This is what we call Intergenerational Trauma. As the descendant population keeps growing, so will experiences with trauma and its many negative outcomes.

Collectively, the impact of these historical laws, policies and practices has resulted in what Justice Deane referred to as a 'legacy of unutterable shame'.[445]

The effects of intergenerational trauma are well-documented in the following key reports:

- *Indigenous deaths in custody 1989 to 1996* **(1996):** in which the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner utilised coronial reports to determine whether recommendations arising from the Royal Commission into Aboriginal Deaths in Custody had been adequately implemented;[446]

- *Bringing them home* **(1997):** the final report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families traces the past laws, practices and policies that resulted in the forced removal of children and made recommendations to support healing and reconciliation;[447]

- *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples* **(1997), (1999), (2001), (2003), (2005), (2008), (2011) and (2018):** this series of reports published by the Australian Institute of Health and Welfare provide a statistical overview of Aboriginal health and welfare, including demographic characteristics, determinants of health and welfare, health and function, mortality and life expectancy, health across the life stages, health care and other support services and health and welfare expenditure;[448]

- *The Gordon Inquiry* **(2002):** which examined the responses by government agencies to complaints of family violence and child abuse in Western Australian Aboriginal communities;[449]

- *National Indigenous Health Equality Summit Outcomes Report* **(2008):** contains the targets and benchmarks under which the Council of Australian Government's

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[444] Healing Foundation, *New report sheds light on disadvantage for the Stolen Generations and their descendants*, 2018, <https://www.healingfoundation.org.au//app/uploads/2018/09/Stolen_Generation_Demographic_Report_Factsheet_Jun2018_V7.pdf>, p. 4.

[445] *Mabo and Others v. Queensland* (No. 2) [1992] HCA 23, per Deane and Gaudron JJ at [50].

[446] Australian Government Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Australian Government, *Indigenous Deaths in Custody 1989 to 1996: A report prepared by the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner for the Aboriginal and Torres Strait Islander Commission*, Aboriginal and Torres Strait Islander Commission, Canberra, October 1996.

[447] Wilkie M, Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, Sydney: Human Rights and Equal Opportunity Commission, 1997.

[448] Australian Institute of Health and Welfare, Australian Government, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015,* AIHW, Canberra, 2015; Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018, in brief*, AIHW, Canberra, 2018.

[449] Gordon S, Hallahan K, Henry D, Putting the picture together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, Department of Premier and Cabinet, Perth, 2002.

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commitment to work in partnership to achieve equality in health status and life-expectancy between Indigenous and non-Aboriginal Australians by the year 2030 will be measured, monitored and reported on;[450]

- ***Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues*** **(2008)**: which looked at the evidence on Aboriginal young people with cognitive disabilities and provided best practice principles and recommendations for delivering services that help these young people;[451]

- ***Hear Our Voices*** **(2012)**: a research report on outcomes from community consultations for the development of an empowerment, healing and leadership program for Aboriginal people living in the Kimberley region of Western Australia;[452]

- ***Elders' Report Into Preventing Indigenous Self-Harm and Youth Suicide*** **(2015)**: which brought together the voices of Elders and community leaders from communities affected by the massive and unprecedented increased in Aboriginal youth self-harm and suicide since the 1980s, unaltered by 'the views of professionals, bureaucrats and other people in positions of power';[453]

- ***Solutions That Work*** **(2016)**: a report summarising the work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project in expanding the evidence base for what works in Aboriginal community led suicide prevention;[454]

- ***Learnings from the Message Stick*** **(2016)**: the report of the Western Australian Legislative Assembly Education and Health Standing Committee's Inquiry into Aboriginal youth suicide in remote areas;[455]

- ***My Life My Lead*** **(2017)**: which details the learnings from a series of consultations undertaken by the Australian Government Department of Health and Advisory Group on the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2013*, regarding the 'integral and supportive role culture plays, and … how social factors such as education, employment, justice, income and housing impact on a person's health and wellbeing at each stage of life.';[456]

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[450] Aboriginal and Torres Strait Islander Social Justice Commissioner and the Steering Committee for Indigenous Health Equity, Australian Government, *Close the Gap National Indigenous Health Equality Targets: Outcomes from the National Indigenous Health Equality Summit Canberra, March 18-20, 2008*, Human Rights and Equal Opportunity Commission, Sydney, 2008, pp. 3 and 21.

[451] Calma, T, Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues, Australian Human Rights Commission, Sydney, March 2008, p. 5.

[452] Dudgeon P et al, Hear Our Voices: Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley, Western Australia – Final Research Report, Centre for Research Excellence Aboriginal Health and Wellbeing, Telethon Institute for Child Health, Research and Centre for Child Health Research, University of Western Australia, Perth, 2012.

[453] People Culture Environment, Elders' Report Into Preventing Indigenous Self-Harm and Youth Suicide, 2015.

[454] Dudgeon, P, et al., Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, pp. 3, 28, 36, 39, 41, 44, 53-54.

[455] Education and Health Standing Committee, *Report No. 11: Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*, Legislative Assembly, Parliament of Western Australia, Perth, November 2016.

[456] Department of Health, My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations, Australian Government, Canberra, December 2017, p. 4.

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- ***Royal Commission into Institutional Responses to Child Sexual Abuse Final Report* (2017)**:[457] that sets out important information relating to the unique context and experiences of Aboriginal children's vulnerability to abuse in institutions, including: colonisation, assimilation, missions and history of religious institutions in Australia; the impact of institutional child sexual abuse on connection to culture and continuation of cultural practice; survivors' accounts; the need for Aboriginal healing approaches as part of the service system; kinship care and the Aboriginal Child Placement Principle; and improving the safety of Aboriginal children in youth detention;[458]

- ***Our Healing Our Way* (2017)**: this report sets out the views of participants at Australia's first National Youth Healing Forum on the impact of intergenerational trauma, cultural identify, safety and wellbeing, and existing strengths and new approaches to creating healing for Aboriginal young people;[459]

- ***Close the Gap – 10 Year Review* (2018)**: which assessed efforts to improve Aboriginal health under the Closing the Gap strategy, and found that 'mortality and life expectancy gaps are actually widening due to accelerating non-Indigenous population gains in these areas';[460] and

- ***Government Response to Learnings from the Message Stick* (2018)**: the Government of Western Australia Department of Premier and Cabinet's response to the report of the Inquiry into Aboriginal youth suicide in remote areas.[461]

6.2 Contemporary circumstances for Aboriginal children and young people in Western Australia

As identified by the Healing Foundation:

> Intergenerational Trauma, stemming from over 200 years of constant and deliberate disruption, dislocation and mistreatment of Aboriginal and Torres Strait Islander people, is not just experienced individually but collectively. It is experienced between generations and across communities.[462]

This legacy of historically discriminatory policies and practices, and the long-term impacts of intergenerational trauma, continue to increase Aboriginal and Torres Strait Islander children and young people's vulnerability to poor health and wellbeing outcomes, as noted in the 2018 *Closing the Gap Prime Minister's Report*:

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[457] Royal Commission into Institutional Responses to Child Sexual Abuse, Australian Government, *Final Report*, Attorney-General's Department, Barton, 2017.

[458] Royal Commission into Institutional Responses to Child Sexual Abuse, *A brief guide to the Final Report: Aboriginal and Torres Strait Islander communities*, viewed 22 March 2019, <https://www.childabuseroyalcommission.gov.au/sites/def ault/files/a_brief_guide_to_the_final_report_-_aboriginal_and_torres_strait_islander_communities.pdf>, p. 1.

[459] Healing Foundation, Our Healing Our Way: Leading and shaping our future – National Youth Healing Forum Report, Healing Foundation, Barton, 2017, p. 4.

[460] Holland, C, *Close the Gap 2018: A ten-year review: the Closing the Gap Strategy and Recommendations for Reset*, Close the Gap Steering Committee for Indigenous Health Equality, 2018, p. 3, citing Australian Institute of Health and Welfare, *Trends in Indigenous mortality and life expectancy 2001-2015*, 2017, p. vii.

[461] Department of Premier and Cabinet, Government Response to Learnings from the message stick: the report of the Inquiry into Aboriginal youth suicide in remote areas, Government of Western Australia, Perth, 2018.

[462] Healing Foundation, Our Healing Our Way: Leading and shaping our future – National Youth Healing Forum Report, Healing Foundation, Barton, 2017, p. 4.

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- the Aboriginal infant mortality rate is almost double (1.9 times) the non-Aboriginal rate from 2012 to 2016, with 53 per cent of these deaths caused by perinatal conditions such as birth trauma, foetal growth disorders, pregnancy complications and respiratory and cardiovascular disorders;

- Western Australia had the second highest Aboriginal child (0-4 years) mortality rate over the period 2012-2016;

- Aboriginal children and young people continue to attend school less frequently that non-Aboriginal children and young people, and this has not improved since the commencement of the 'Close the Gap' initiative;

- a lower proportion of Aboriginal students than non-Aboriginal students met National Minimum Standards for reading and numeracy in 2017;

- the Aboriginal employment rate has fallen over the past decade from 48 per cent in 2006 to 46.6 per cent in 2016, and Aboriginal people did not experience rises in employment growth during the mining boom of the early 2000s;

- the most recent life expectancy estimates published showed that a male Aboriginal person born between 2010 and 2012 has a life expectancy of 69.1 years (10.6 years less than a male non-Aboriginal person) while a female Aboriginal person has an estimated life expectancy of 73.7 years (9.5 years less than a female non-Aboriginal person); and

- Aboriginal young people continue to be overrepresented in the youth justice system, and in 2015-16, were 17 times more likely than non-Aboriginal young people to be under supervision orders, and 25 times more likely to be in detention.[463]

Aboriginal young people are also directly impacted by very high rates of psychological distress and exposure to life stressors. Aboriginal young people aged 15 to 19 years reported that the most common stressors are the death of a family member or friend (22 per cent); inability to get a job (22 per cent); serious illness (7 per cent); mental ill-health (7 per cent) and overcrowding at home (7 per cent).[464]

Western Australia is geographically the largest State in Australia, with the third highest Aboriginal population of 76,000 people, which equates to 12 per cent of Australia's total Indigenous population. In 2016, Aboriginal and Torres Strait Islander peoples comprised 3.1 per cent of Western Australia's population, slightly higher than the national rate of 2.8 per cent.[465]

Approximately 40,000 Aboriginal children and young people live in Western Australia, accounting for 40 per cent of the State's total Aboriginal population, and 6.8 per cent of the State's total population of children and young people.[466] While the majority of Western

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[463] Department of the Prime Minister and Cabinet, Australian Government, *Closing the Gap: Prime Minister's Report 2018*, Department of the Prime Minister and Cabinet, Canberra, 2018, pp. 9, 38, 53, 76, 104 and 120.

[464] Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018: in brief, AIHW, Canberra, 2018.

[465] Australian Bureau of Statistics, *Media Release: 2016 Census shows growing Aboriginal and Torres Strait Islander population*, ABS, Canberra, 2017, viewed 28 October 2019, <http://www.abs.gov.au/ausstats/abs@.nsf/MediaReales esByCatalogue/02D50FAA9987D6B7CA25814800087E03?OpenDocument>.

[466] Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2016', *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.

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Australian Aboriginal children and young people meet or exceed all relevant developmental milestones,[467] Aboriginal children and young people are significantly over-represented in the out of home care and juvenile justice systems, comprising 66 per cent of the children and young people under youth justice supervision in Western Australia during 2015-2016[468] and 54 per cent of the children and young people in the care of the CEO of the Department of Communities in 2016-17.[469]

Many Aboriginal children and young people are disproportionately exposed to grief, trauma, loss and discrimination which greatly affects their social and emotional wellbeing:[470]

> Many also experience a range of negative impacts associated with chronic economic disadvantage, lack of access to appropriate support services, ongoing discrimination by the criminal justice, limited educational and employment opportunities, loss of Elders and other adult family members and mentors due to early deaths or imprisonment'.[471]

However, it is important to acknowledge that, in the face of these challenges, Aboriginal peoples have demonstrated great resilience and strength over a long period of time and remain at the forefront of efforts to reduce this disadvantage and achieve social and economic equity for their communities through self-determination and culturally informed solutions.

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[467] KidsMatter, Aboriginal infants and children: supporting and promoting their wellbeing and development, Telethon Kids Institute, Perth, 2010, p. 4.

[468] Commissioner for Children and Young People Western Australia, *Profile of Children and Young People in WA*, November 2017, p. 20.

[469] Department of Communities, *Additional Performance Information: Final Report 2016-2017*, 2017, viewed 22 March 2019, p. 11.

[470] Chalmers KJ et al, 'Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus guidelines', *International Journal of Mental Health Systems*, vol. 8, no. 6, 2014, citing Zubrick S et al, *The Western Australian Aboriginal child health survey: the social and emotional wellbeing of Aboriginal children and young people*, Technical Report, July 2005.

[471] Scrine C et al, Suicide prevention for Aboriginal and Torres Strait Islander young people: Fact Sheet 3 for the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, Telethon Kids Institute and the University of Western

Australia, Perth, 2015 viewed 22 March 2019, <https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/natsispep/fact-sheet-no-3.pdf>, p. 1, citing Higgins D and Davis K, Law and justice: prevention and early intervention programs for Indigenous youth, Resource sheet no. 34, Closing the

Gap Clearinghouse, Canberra, viewed 22 March 2019, <https://www.aihw.gov.au/getmedia/85dd676d-62ab-47cf-8a01-a1847a05a17a/ctg-rs34.pdf.aspx?inline=true>.

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6.3   Prevalence of suicide by Aboriginal children and young people

Historically, suicide by Aboriginal people was extremely rare and 'almost unheard of prior to the 1960s'.[472] Beginning in the 1980s, an upward trend began in the number of Aboriginal people who died by suicide that has continued today.

The research literature identifies that, when compared with global suicide rates, the Aboriginal suicide rate in Australia ranks as the 12th highest in the world (Figure 70).

Figure 70: Global suicide rates with the Aboriginal and Torres Strait Islander suicide rate and Australian suicide rate ranked separately against selected countries, 2012
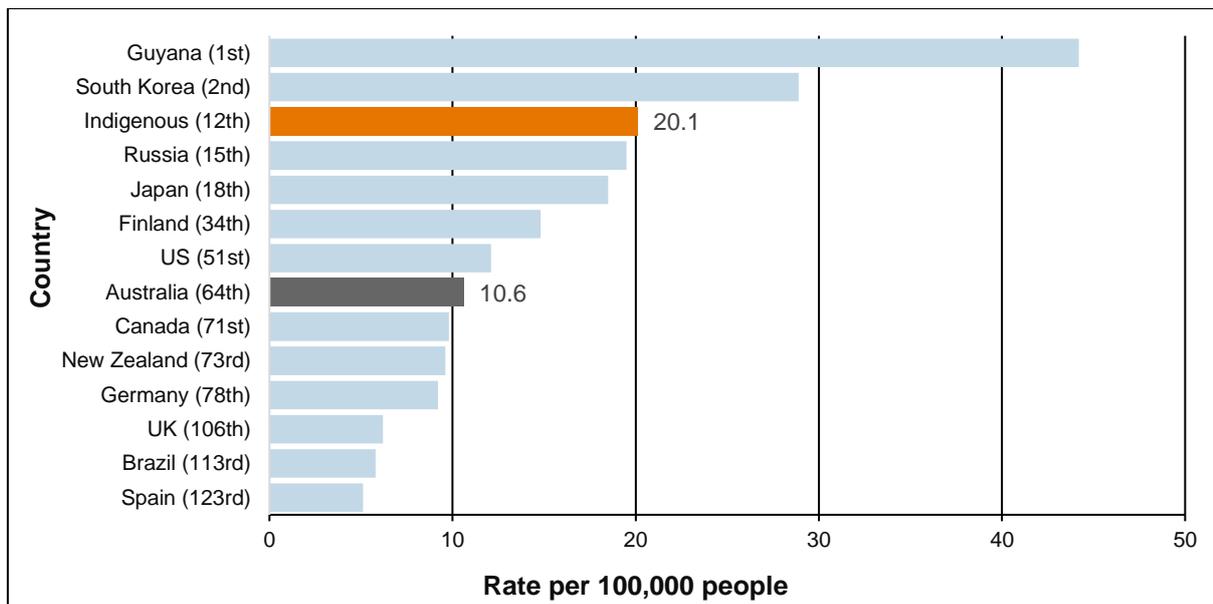
Source: Ting, WHO, ABS, Dudgeon et al., 2016[473]

However, even when compared with other Australian States and Territories, Western Australia had the highest Aboriginal suicide rates in Australia between 2008 and 2016.

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[472] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 6, citing Hunter E and Milroy H, 'Aboriginal and Torres Strait Islander Suicide in Context', Archives of Suicide Research, vol. 10, pp. 141-157.

[473] Ting I and Hunter F, 'Indigenous suicide rate 12th highest in the world', *The Sydney Morning Herald*, 10 July 2015, viewed 14 February 2020, <https://www.smh.com.au/healthcare/indigenous-suicide-rate-12th-highest-in-the-world-20150710-gi9jyn.html>; World Health Organization, *Preventing suicide: a global imperative*, Luxembourg, 2014, pp. 80-87; ABS, 'Table 11.4 – Intentional self-harm by Indigenous status', *Causes of Death, 2013*, cat no. 3303.0, ABS, Canberra, March 2015; Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, p. 6.

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Figure 71: Aboriginal and/or Torres Strait Islander suicide, by state
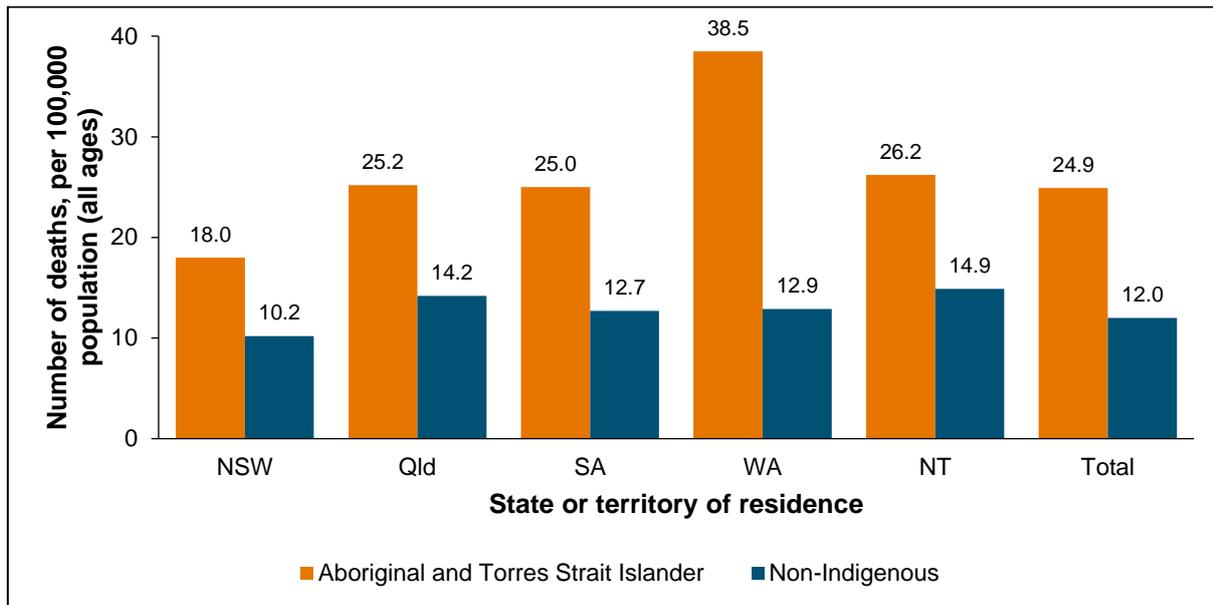
Source: ABS[474] Dudgeon et al, 2016[475]

In the five years from 2013 to 2017, suicide was the leading cause of death for Aboriginal people aged between 15 and 34 years of age, and was the second leading cause of death for Aboriginal people aged between 1 and 14 years of age.[476] Further, Aboriginal and Torres Strait Islander children and young people accounted for more than a quarter of all suicide deaths in children aged between 5 and 17 years of age (93 of the 358 deaths, 26 per cent).[477]

A 2012 study of Western Australian Aboriginal people found that almost all (97 per cent) respondents had been exposed to traumatic events, 55 per cent of whom had been diagnosed with for post-traumatic stress disorder. The study also found that 20 per cent of participants self-reported experiences of depression over their lifetime and 73 per cent met the diagnostic criteria for alcohol abuse or dependence.[478]

As identified in Chapters 3.5.7 and 6 of this volume, Aboriginal and Torres Strait children and young people were significantly over-represented among the 115 children and young people, with 43 children and young people identifying as Aboriginal or Torres Strait

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[474] Australian Bureau of Statistics, 'Table 11.4 – Intentional self-harm by Indigenous status', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

[475] Dudgeon, P, et al., Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 6, citing Hunter F and Ting I, 'Indigenous suicide rate 12th highest in the world', Sydney Morning Herald, 10 July 2015, viewed 25 March 2019, <http://www.smh.com.au/national/health/Indigenous-suicide-rate-12th-highest-in-the-world-20150710- gi9jyn.html>.

[476] Australian Bureau of Statistics, 'Table 11.4 – Intentional self-harm by Indigenous status', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

[477] Australian Bureau of Statistics, 'Table 11.12 – Intentional self-harm, Number of deaths in children aged 5-17 years by Aboriginal and Torres Strait Islander status, NSW, Qld, SA, WA and NT, 2013-2017', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018.

[478] Dudgeon, P, et al., Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 71, , citing Nadew, G, 'Exposure to traumatic events, prevalence of Posttraumatic Stress Disorder and alcohol abuse in Aboriginal communities', Rural and Remote Health, vol. 12, 2012, p.1667.

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Islander in the records obtained during the 2014 and 2020 Investigations (37 per cent). This over-representation reflects higher rates of suicide by Indigenous people across the world[479] and for Aboriginal and/or Torres Strait Islander people as compared to non-Aboriginal Australians.[480]

6.4 Patterns in the characteristics of the Aboriginal children and young people who died by suicide in Western Australia

6.4.1 Factors associated with suicide

ATSISPEP identified that culture and connection are key to preventing suicide by Aboriginal and Torres Strait Islander children and young people:

> … growing up in a healthy, safe, supportive environment, with a strong connection to culture, community and school … It is critically important that we gain a better understanding of the cumulative and complex impact of stress exposures over the life-course to ensure appropriate preventative responses and address the negative trajectory of suicidal behaviour, which can start at a young age.
>
> This will be facilitated in part by enhancing and increasing the number of appropriate services and programs to support families and children. It is important that all Indigenous children have access to the supports and strategies offered by early child care that help them build coping skills, resilience and self-regulation from a young age. …
>
> Adequate follow up care to children at risk and monitoring any attempt at self-harm is critical, as well as ensuring access to appropriate services and strategies to foster help-seeking behaviour among Indigenous children.[481]

Aboriginal and Torres Strait Islander children and young people face different risk factors to the non-Aboriginal population as a result of the ongoing impact of past government laws, policies and practices, namely:

- stress associated with bullying, harassment, peer rejection, failure and disengagement at school and stress associated with family violence, overcrowding, poverty, and alcohol and cannabis misuse in the household;[482]

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[479] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014,
p. 36.

[480] Australian Bureau of Statistics, 'Table 11.4 – Intentional self-harm by Indigenous status', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

[481] ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>, p. 2.

[482] ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>.

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- high levels of stress and isolation arising from their roles as carers of parents and siblings with mental health disorders or disabilities;[483] and

- racism, which has been shown to exacerbate mental health issues, negate the protective effects of parenting and family function, limit the capacity of parents to promote child development and access culturally appropriate supports for their family, and is associated with poor physical and mental health and negative social and emotional wellbeing of children (including anxiety, depression, low self-esteem, suicide and self-harm).[484]

The Office identified that 35 (81 per cent) of the 43 Aboriginal and Torres Strait Islander children and young people were recorded as having experienced multiple factors associated with suicide, including:

- 36 of the 43 (84 per cent) Aboriginal and Torres Strait Islander children and young people were recorded as having allegedly experienced some form of child abuse or neglect that was reported to the Department of Communities; and

- 35 of the 43 (81 per cent) Aboriginal and Torres Strait Islander children and young people were recorded as having allegedly experienced child abuse or neglect in conjunction with other factors associated with suicide, including suicidal behaviour and ideation (24 children and young people, 50 per cent), mental health issues (19 children and young people, 44 per cent), substance use (27 children and young people, 63 per cent) and adverse family experiences (32 children and young people, 74 per cent).

The research literature however also identifies many strengths which have allowed Aboriginal and Torres Strait Islander children and young people to be resilient, survive and thrive in the face of such high levels of adversity, including:

- strong cultural identity and belief systems

- extensive kinship systems which are socially inclusive

- broader attachment models

- cultural and spiritual strengths including connection to country and ancestry

- strong child rearing practices

- early autonomy and self-reliance

- cultural ways of learning

- role of traditional healers and ceremony

- focus on healing.[485]

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[483] ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>.
[484] ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>.
[485] Healing Foundation, *Working with Aboriginal and Torres Strait Islander young people and their families*, viewed 2 April 2019, <https://healingfoundation.org.au//app/uploads/2018/07/HF-Young-People-fact-sheet.pdf>.

The factors associated with suicide experienced by the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide are summarised in Figure 72.

Figure 72:Factors associated with suicide, for the 43 Aboriginal and Torres Strait Islander children and young people, by Ombudsman Investigation

Child or young person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
1	■	■	■	■	■
2	■	■	■	■	■
5	■	■	■	■	
6	■	■	■	■	■
11	■	■		■	■
14	■		■	■	■
16			■	■	
17		■		■	■
18	■			■	
19		■		■	
34	■				
35		■			
36					
38	■	■	■	■	■
39			■		
40	■	■	■	■	
41		■	■	■	
42		■	■	■	
43	■	■	■	■	■
50	■	■		■	■
51	■	■	■	■	■
53	■	■	■	■	
55	■	■	■		■
56	■	■	■		■
57	■	■	■		■
58	■	■	■		■
59	■		■	■	■
61	■		■	■	■
62	■	■	■	■	■
63	■	■	■	■	
67	■		■		■
68			■	■	
69			■	■	
70			■	■	■
71				■	
77				■	
78	■	■	■	■	■
82			■	■	
83			■		
84		■	■		
105	■				
112					
115		■			

■ Factor experienced by an Aboriginal or Torres Strait Islander young person who died by suicide during the 2014 Investigation Period

■ Factor experienced by an Aboriginal or Torres Strait Islander child or young person who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

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More detail about the factors associated with suicide experienced by the Aboriginal and Torres Strait Islander children and young people is provided below.

Child abuse or neglect

Records indicate that, of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide:

- 32 allegedly experienced neglect (74 per cent);

- 29 allegedly experienced family and domestic violence (67 per cent);

- 18 allegedly experienced sexual abuse (42 per cent);

- 14 allegedly experienced other emotional or psychological abuse (33 per cent); and

- 19 allegedly experienced physical abuse (44 per cent).

Suicidal ideation and behaviour

Records indicate that, of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide:

- 21 demonstrated suicidal ideation (49 per cent);

- 16 expressed communicated their intention to die by suicide to a friend, family member or health professional (37 per cent); and

- 15 had previously attempted suicide (35 per cent).

Mental health issues

Records indicate that, of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide:

- four self-harmed (9 per cent); and

- one was diagnosed with a mental health disorder (2 per cent).

Substance use

Records indicate that, of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide:

- 23 consumed alcohol at some time in their lives (53 per cent); and

- 20 had consumed cannabis or other illicit drugs at some time in their lives (47 per cent).

Adverse family experiences

Records indicate that, of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide:

- 20 had a parent who had experienced a mental health condition (47 per cent);

- 26 had a parent who had problematic alcohol and/or other drug use (60 per cent);

- 14 had a parent who was imprisoned (33 per cent); and

- 8 had a family member, friend or person known to them who had died by suicide (19 per cent).

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6.4.2 Demographic characteristics

Records indicate that the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide ranged in age from 10 to 17 years, including:

- 7 children aged 10 to 13 years (16 per cent), 15 young people aged 14 to 15 years (35 per cent); and 21 young people (49 per cent) aged 16 to 17 years. In comparison, among the 72 non-Aboriginal children and young people four were children were aged 10 to 13 years (5 per cent); 20 were aged 14 to 15 years (28 per cent) and 48 were aged 16 to 17 years at the time of their death (66 per cent);

- 22 (51 per cent) were male and 21 (49 per cent) were female, compared to 50 males (69 per cent) and 22 females (31 per cent) among the 72 non-Aboriginal children and young people; and

- 11 children and young people who resided in a major city (26 per cent), six children and young people who resided in a regional area (14 per cent), seven young people who resided in a remote area and 19 children and young people (44 per cent) who resided in a very remote region. All of the children and young people who died in a very remote area were Aboriginal. By way of comparison, 55 non-Aboriginal children and young people resided in a major city (76 per cent), 16 non-Aboriginal young people resided in a regional area (22 per cent) and 1 non-Aboriginal young person resided in a remote area (1 per cent).

6.4.2.1   Age

The Aboriginal and/or Torres Strait Islander population has a significantly different age distribution to the normally distributed population of non-Aboriginal people due to higher fertility and mortality rates,[486] meaning that the Aboriginal population has a larger proportion of younger people and fewer older people, when compared to the non-Aboriginal and/or Torres Strait Islander population, as shown in Figure 73.

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[486] Australian Institute of Health and Welfare, Australian Government, 'The Indigenous population key points', *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015*, AIHW, Canberra, 9 June 2015.

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Figure 73: Percentage of population for Aboriginal and non-Aboriginal persons in 2016, by five-year age groups[487]

Aboriginal and Torres Strait Islander persons	Age group	Non-Aboriginal persons
0.3	85 years and over	2.1
0.4	80–84 years	2.0
0.7	75–79 years	2.8
1.3	70–74 years	3.8
2.1	65–69 years	5.2
3.0	60–64 years	5.6
4.0	55–59 years	6.3
4.8	50–54 years	6.6
5.6	45–49 years	6.8
5.7	40–44 years	6.8
5.5	35–39 years	6.7
6.3	30–34 years	7.3
7.4	25–29 years	7.1
8.9	20–24 years	6.6
10.2	15–19 years	6.0
11.0	10–14 years	5.9
11.7	5–9 years	6.3
11.3	0–4 years	6.1

Source: ABS[488] and Ombudsman Western Australia

Healthy communities need an adequate number of healthy adults to care for the next generation. When considered in the context of Aboriginal and Torres Strait Islander peoples' experiences of poorer health, higher rates of disability, significantly higher rates of imprisonment and child removal, increased rates of substance misuse, exposure to more traumatic events and lower household incomes than the general population, the number of adults that are available to care for children is dramatically impacted.[489] This means that, often, children and young people themselves are burdened with care responsibilities for siblings, or parents with health issues, disability or substance misuse issues.

6.4.2.2 Sex

Historically, female and children and young people have been viewed in the research literature as being at a lower risk of dying by suicide.[490] However the circumstances in which Aboriginal and Torres Strait Islander children and young people died by suicide, as outlined in Chapter 3.6 of this volume, indicates that this traditional concept of being female as a protective factor against suicide is not applicable to Aboriginal and Torres Strait Islander children and young people.

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[487] Australian Bureau of Statistics, 'Introduction', *Census of Population and Housing: Estimating homelessness*, cat. no. 2049.0, ABS, Canberra, 14 March 2018.
[488] Australian Bureau of Statistics, Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016 – Aboriginal and Torres Strait Islander Population, cat. no. 2071.0, ABS, Canberra, 20 March 2018.
[489] Department of Health, Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, 27 June 2013, viewed 6 May 2019,
<http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc~priorities~whole-life>.
[490] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014.

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Further, female Aboriginal and Torres Strait Islander children and young people are dying by suicide at a younger age than their non-Aboriginal and Torres Strait Islander counterparts, with the median age at the time of death for female Aboriginal and Torres Strait Islander children and young people being 15 years, whilst for non-Aboriginal and Torres Strait Islander female children and young people, it is 16 years.

6.4.2.3   Region of residence

A greater number of Aboriginal and Torres Strait Islander children and young people died by suicide in remote and very remote areas. However, this does not indicate that all Aboriginal and Torres Strait Islander children and young people living in a remote or very remote area are at increased risk of suicide by virtue of this factor alone. Of the 26 Aboriginal and Torres Strait Islander children and young people who died by suicide and lived in a remote or very remote area, 10 individual remote Aboriginal communities were identified, representing only 4 per cent of the 274 remote Aboriginal communities in Western Australia.

Canadian researchers who mapped deaths by suicide in all 197 First Nations communities in British Columbia, found that communities which had achieved the following markers of cultural continuity, experienced no cases of suicide by First Nations children and young people:

- self-government;[491]

- land rights litigation;[492]

- local control over health, education, and police services;[493] and

- operation of cultural facilities.[494]

In communities that had not achieved any of the above protective markers, youth suicide rates were reported to be up to 800 times greater than the average.[495] Subsequent Australian research has noted that the current arrangements for governance, funding and service delivery in Australian Aboriginal communities have hampered progress towards community control over the affairs of Aboriginal people.[496]

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[491] Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.
[492] Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.
[493] Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.
[494] Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.
[495] Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.
[496] Hunter, E, 'Indicators of psychoses or psychoses as indicators: the relationship between Indigenous social disadvantage and serious mental illness', *Australasian Psychiatry,* vol. 21, no. 1, pp. 22–26; Ridani R et al, 'Suicide Prevention in Australian Aboriginal Communities: A Review of Past and Present Programs; *Suicide and Life Threatening Behavior*, vol. 45, no. 1, February 2015, pp. 111-140; Dudgeon P et al., *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, pp. 60-61.

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Children and young people living in regional and remote parts of Western Australia experience unique challenges in addressing mental health issues, particularly in the context of access to services:

> Currently, there is no overarching framework of guidelines, policy and best practice for mental health in primary care at a national level, and there are few resources available for providing mental health assessment and quality feedback and outcome measurement. Mental health policy and program initiatives and service delivery have been widely criticised in recent decades for failing to provide culturally appropriate programs and services at both macro and micro levels.

> For decades, mainstream mental health services have been provided on the basis of an inherent ethnocentrism, resulting in widespread systemic failure to respond to the needs of Indigenous people.[497]

There is a lack of services that are culturally informed in regional and remote Western Australia. An inquiry by the Commissioner for Children and Young People into the mental health and wellbeing of Western Australian children and young people found that:

> Children and young people living in regional and remote parts of Western Australia face particular and unique challenges in terms of mental health, especially around accessing services. …

> … there is a lack of services and programs in regional and remote communities to address the mental health and wellbeing of children and young people. In particular, there is an acute shortage of services and programs for children and young people who require early intervention and/or treatment services because they have a mental health illness. …

> A lack of access to mental health professionals means that it may not be possible to arrange referrals when mental health issues are identified. The considerable distances that must be travelled in order to access appropriate services may also have a deleterious impact on children and young people.[498]

Families with limited income and few transport options are further disadvantaged as accessing services is beyond their means.

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[497] Dudgeon P, et al, Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people: Issues Paper No. 12, Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Australian Government, November 2014, viewed 6 May 2019, <https://www.aihw.gov.au/reports/indigenous-australians/effective-strategies-to-strengthen-mental-health-w/contents/table-of-contents>.
[498] Commissioner for Children and Young People, The mental health and wellbeing of children and young people: Children and young people living in regional and remote areas - Policy Brief, October 2012, viewed 25 March 2019, <https://www.ccyp.wa.gov.au/media/1297/policy-brief-mental-health-regional-and-remote-areas-october-2012.pdf>.

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7. Patterns and trends in the characteristics of the children and young people who died by suicide

7.1 The 2014 Investigation identified four distinct groups of young people who died by suicide

In the 2014 Investigation, the Office analysed the patterns in the characteristics of the 36 young people who died by suicide, including the demographic characteristics, risk factors, warning signs and precipitating events experienced by the 36 young people (referred to as **factors associated with suicide**) as summarised in Figure 74.

Figure 74: Factors associated with suicide, by category

Category	Factors associated with suicide
Mental health issues	• Mental illness • Self-harming behaviour
Suicidal ideation and behaviour	• Suicidal ideation • Previous suicide attempts • Communicated suicidal intent
Substance use	• Alcohol or other drug use
Child abuse or neglect	• Family and domestic violence • Sexual abuse • Physical abuse • Neglect
Adverse family experiences	• 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

The Office also considered the contact each of the 36 young people was recorded as having with the following State government departments and authorities:

- Child and Adolescent Mental Health Service (**CAMHS**);

- Department of Communities, Child Protection division (**CPFS**);

- Department of Communities, Housing division (**Housing**)

- Department of Justice;

- Government schools;

- Government and non-government registered training organisations;

- WA Health; and

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- Western Australia Police.

As shown in Figure 75, the 2014 Investigation identified four groups of young people based on patterns in the factors associated with suicide, contact with State government departments and authorities, and relevant suicide prevention activities.

Group 1 – Young people who were all recorded as having allegedly experienced one or more forms of child abuse or neglect, including family and domestic violence, sexual abuse, physical abuse, psychological or emotional abuse, and neglect. Most of the young people in Group 1 were also recorded as having experienced mental health issues and suicidal ideation and behaviour.

Group 2 – Young people who were recorded as having one or more diagnosed mental health disorders, a parent with a diagnosed mental health disorder and/or had demonstrated significant planning for their suicide. None of these young people were recorded as having allegedly experienced child abuse or neglect.

Group 3 – Young people who experienced few factors associated with suicide. None of these young people were recorded as having allegedly experienced child abuse or neglect, mental health issues or adverse family experiences. All of these young people were recorded as being highly engaged in school and/or highly involved in sport.

Group 4 – Young people who experienced few factors associated with suicide and were not recorded as having allegedly experienced child abuse or neglect, a mental health issues or adverse family experiences, like the young people in Group 3. However, records indicated that all of these young people demonstrated impulsive or risk-taking behaviour.

The patterns identified by the Office in the 2014 Investigation were consistent with similar investigations carried out by Child Death Review teams in New South Wales[499], Queensland[500] and British Columbia, Canada,[501] each of which identified two groups of young people who died by suicide:

- young people who experienced significant and enduring life difficulties, including alleged child abuse or neglect and family dysfunction, mental health issues, school related difficulties or any combination of these factors. This group made up 66 to 80 per cent of cases across the three studies; and

- young people who had experienced a precipitating or 'life changing' event in absence of chronic family, relationship or mental health issues. This group made up to 20 to 26 per cent of cases reviewed across the three studies.

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[499] Sankey S and Lawrence R, *Suicide and risk-taking deaths of children and young people,* New South Wales Commissioner for Children and Young People, Sydney, 2003.
[500] Commissioner for Children and Young People and Child Guardian, *Reducing Youth Suicide in Queensland: Final Report*, Queensland Government, Brisbane, 2011.
[501] 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.

Figure 75: Groups identified in the 2014 Investigation, their contact with State government departments and authorities and relevant suicide prevention activities

Group 1	Group 2	Group 3	Group 4
Characteristics			
20 young people: • all allegedly experienced one or more forms of child abuse or neglect; • most also experienced mental health issues and suicidal ideation and behaviour.	5 young people who had: • one or more diagnosed mental illnesses; or • a parent with a diagnosed mental illness; and/or • demonstrated significant planning for their suicide. • none allegedly experienced child abuse or neglect	6 young people who: • experienced few factors associated with suicide; • all were recorded as being high achievers or highly engaged in school education and/or sport; and • had no history of child protection concerns.	5 young people who: • experienced few factors associated with suicide; and • had no recorded mental health problem or adverse family experiences; and • were recorded as having demonstrated impulsive or risk taking behaviour.
Contact with State government departments and authorities			
All of the young people in Group 1 were known to the: • (then) Department for Child Protection and Family Support; and • Department of Health. These young people also had extensive contact with other State government department and authorities including registered training organisations, the justice system and the Department of Housing.	Most of the young people in Group 2 had contact with the (then) Child and Adolescent Mental Health Service and government schools.	The young people in Group 3 had minimal contact with State government departments and authorities. Some were known to the Department of Health and/or had contact with a registered training organisation. Most attended private schools.	All of the young people in Group 4 had contact with the Department of Health and government schools. Most were also known to the (then) Department for Child Protection and Family Support for financial or crisis support.
Relevant suicide prevention activities			
Interventions that recognise and address the developmental impacts of child abuse, neglect and other forms of childhood adversity, including: • effective prevention, identification, response and therapeutic interventions for cumulative harm from abuse and neglect; • improved collaboration and cooperation between government agencies, including information sharing; and • early intervention and/or ongoing care and support.	Interventions that promote and enhance mental health, including: • symptom identification; • early, standard and longer term treatment of mental health problems; and • ongoing care and support.	Universal, selective and indicated interventions. Further research may be required.	Universal interventions. Selective and indicated interventions, targeting at risk Aboriginal and/or rural communities and individuals.

Source: Ombudsman Western Australia

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7.1.1 Among the 79 children and young people who died by suicide in Western Australia during the 2020 investigation period, there continue to be four identifiably distinct groups of children and young people

In order to further investigate patterns and trends in the lives of the children and young people who died by suicide in Western Australia, the Office analysed the patterns and trends in the factors associated with suicide and contact with State government departments and authorities for the 79 children and young people who died by suicide during the 2020 investigation period using:

- information from child death review notifications;

- other information and records obtained during child death reviews conducted by the Office; and

- information obtained from the Department of Communities, Department of Education and Mental Health Commission.

Through this analysis, the Office has identified that the 79 children and young people are also distinguishable from each other by patterns in the factors associated with suicide, their contact with State government departments and authorities and relevant suicide prevention interventions. Broadly, the 79 children and young people are readily classified by way of reference to the same four groups identified in the 2014 Investigation.

This Chapter discusses these four groups of children and young people as they relate to the 115 children and young people, in further detail. Additionally, this Chapter also considers the patterns and trends in the characteristics of the 11 children aged 10 to 13 who died by suicide as a potentially new and emerging group.

7.2 Children who died by suicide

Tragically, as identified in the Ombudsman's Annual Reports and reported in the media, 11 children aged 10 to 13 years died by suicide in Western Australia during the 2020 Investigation.[502] As discussed in Chapter 3 of this volume, there are relatively few models for understanding and explaining suicide by children. The research literature indicates that:

- by the age of six to seven years, two thirds of children understand the concept of dying and know that everyone dies at some point and cannot be 'reawakened or brought back to life with magic powers';[503] and

- by eight years of age, children have a thorough understanding of suicide and are capable of carrying it out.[504]

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[502] Australian Broadcasting Corporation, 'Indigenous suicide inquest told rate of death's in WA's north has 'reached disturbing proportions', 26 June 2017, viewed 22 September 2018, <http://www.abc.net.au/news/2017-06-26/indigenous-suicide-in-north-wa-unacceptable-inquest-told/8652118>.

[503] headspace School Support, *Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary,* <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res2.pdf>, p. 5.

[504] Centre for Suicide Prevention, *Children and Suicide Resource Toolkit*, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

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However, there is increasing acceptance in the child development and suicidality literature that 'the intent to cause self-harm or death is most important, regardless of the child's cognitive understanding of the lethality, finality or outcome of their actions'.[505]

In children, suicide attempts may be more likely to be impulsive, arising from feelings of 'sadness, confusion, anger, or problems with attention and hyperactivity'[506] or:

> They may just wish to end their emotional pain without fully understanding the consequences of their actions.[507]

The research literature recognises that suicide attempts in childhood are a major predictor of future suicide in later adolescence and adulthood,[508] with children who attempt suicide being 'up to 6 times more likely to attempt suicide again in adolescence'.[509]

Accordingly, given that 11 (14 per cent) of the 79 children and young people were aged between 10 and 13 years at the time of their death, the Office conducted a separate analysis of the demographic characteristics and factors associated with suicide that were recorded for each of these children, in order to better understand future opportunities to prevent or reduce suicide by children in Western Australia for this particular age group.

7.2.1 Factors associated with suicide

The Office identified that eight (73 per cent) of the 11 children were recorded as having experienced multiple factors associated with suicide. Ten of these 11 children (90 per cent) were recorded as having allegedly experienced some form of child abuse or neglect that was reported to the Department of Communities. Seven of these 11 children (63 per cent) were recorded as having allegedly experienced child abuse or neglect in conjunction with other factors associated with suicide, including suicidal ideation (two children), mental health issues (three children), substance use (three children) and adverse family experiences (six children).

The factors associated with suicide experienced by the 11 children who died by suicide are summarised in Figure 76:

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[505] headspace School Support, *Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary,* <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res2.pdf>, p. 5.

[506] American Academy of Child and Adolescent Psychiatry, 'Suicide in Children and Teens', June 2018, viewed 28 October 2019, <https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx>.

[507] Centre for Suicide Prevention, *Children and Suicide Resource Toolkit*, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

[508] Centre for Suicide Prevention, *Children and Suicide Resource Toolkit*, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

[509] Centre for Suicide Prevention, *Children and Suicide Resource Toolkit*, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

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Figure 76: Factors associated with suicide for, the 11 children

Young Person ID	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
37				■	
39			■	■	
50		■		■	■
60		■	■	■	■
61	■		■	■	■
63	■	■	■	■	
68			■	■	
69			■	■	
72				■	
77				■	
107	■				■

■ Factor experienced by a child who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

The factors associated with suicide experienced by the children who died by suicide are summarised below:

Child abuse or neglect

Records indicate that, of the 11 children aged between 10 and 13 years at the time of their death:

- 5 allegedly experienced family and domestic violence;

- 4 allegedly experienced sexual abuse;

- 2 allegedly experienced physical abuse; and

- 7 allegedly experienced neglect.

Suicidal ideation and behaviour

Records indicate that, of the 11 children aged between 10 and 13 years at the time of their death:

- 3 demonstrated suicidal ideation;

- 1 communicated their intention to die by suicide to a friend, family member or health professional; and

- 1 had previously attempted suicide.

Mental health issues

Records indicate that, of the 11 children aged between 10 and 13 years at the time of their death:

- 4 self-harmed; and

- 1 was diagnosed with a mental health disorder.

Substance use

Records indicate that, of the 11 children aged between 10 and 13 years at the time of their death:

- 2 consumed alcohol at some time in their lives; and

- 2 consumed illicit drugs at some time in their lives.

Adverse family experiences	Records indicate that, of the 11 children aged between 10 and 13 years at the time of their death:

- 2 had a parent with a mental health disorder;

- 4 had a parent who had problematic alcohol and/or other drug use;

- 4 had a parent who was imprisoned; and

- 2 had a family member, friend or person known to them who had died by suicide.

7.2.2 Demographic characteristics

Records indicate that, of the 11 children aged between 10 and 13 years at the time of their death:

- 7 were female (64 per cent) and four were male (36 per cent);

- 7 were Aboriginal (64 per cent) and four were non-Aboriginal (36 per cent); and

- 5 resided in a major city (45 per cent), two resided in a regional area (18 per cent), and four lived in a very remote region (36 per cent).

7.3 Children and young people in Group 1

7.3.1 Factors associated with suicide

The Office identified that 70 of the 115 children and young people (61 per cent) were recorded as having experienced multiple factors associated with suicide. Each of the 70 children and young people was recorded as having allegedly experienced some form of child abuse or neglect. Sixty-four of these 70 children and young people (91 per cent) were recorded as having allegedly experienced child abuse or neglect in conjunction with other factors associated with suicide, including suicidal ideation (48 children and young people), mental health issues (43 children and young people), substance use (45 children and young people) and adverse family experiences (53 children and young people). In this report, this group of children and young people is referred to as **Group 1**.

The factors associated with suicide experienced by the children and young people in Group 1 are summarised in Figure 77.

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Figure 77: Factors associated with suicide experienced by the young people in Group 1 of the 2014 Investigation

Young Person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
1	■	■	■	■	■
2	■	■	■	■	■
3	■	■	■	■	■
4	■	■	■	■	■
5	■	■	■	■	
6	■	■	■	■	■
7	■	■		■	■
8	■	■	■	■	■
9	■	■	■	■	■
10	■	■		■	■
11	■	■		■	■
12	■	■		■	
13	■		■	■	■
14	■		■	■	■
15	■			■	■
16			■	■	
17		■		■	■
18	■		■	■	
19		■	■	■	
20				■	

■ Factor experienced by a young person who died by suicide during the 2014 Investigation Period

Source: Ombudsman Western Australia

Figure 78: Factors associated with suicide experienced by young people in Group 1 of the 2020 Investigation

Young Person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
37				▓	
38	▓	▓		▓	▓
39			▓	▓	
40	▓	▓		▓	
41		▓		▓	
42		▓		▓	
43		▓			
44	▓	▓	▓	▓	▓
45	▓		▓	▓	▓
46	▓	▓		▓	▓
47		▓		▓	▓
48	▓		▓	▓	▓
49	▓	▓	▓	▓	
50		▓		▓	▓
51	▓		▓	▓	▓
52	▓		▓	▓	▓
53	▓	▓	▓	▓	
54	▓	▓	▓	▓	▓
55	▓	▓	▓	▓	
56	▓	▓	▓	▓	▓
57	▓		▓	▓	
58	▓		▓	▓	▓
59	▓		▓	▓	▓
60		▓	▓	▓	▓
61	▓		▓	▓	▓
62		▓	▓	▓	
63	▓		▓	▓	
64			▓	▓	
65	▓	▓	▓	▓	▓
66	▓	▓	▓	▓	▓
67	▓	▓	▓	▓	▓
68			▓	▓	
69			▓	▓	
70			▓	▓	▓
71				▓	
72				▓	
73	▓	▓		▓	▓
74	▓		▓	▓	▓
75	▓	▓	▓	▓	▓
76	▓	▓	▓	▓	
77				▓	
78	▓	▓	▓	▓	▓
79	▓	▓		▓	▓
80	▓	▓	▓	▓	▓
81	▓		▓	▓	▓
82			▓		
83			▓		
84		▓	▓	▓	
85	▓		▓	▓	▓
86	▓		▓	▓	▓

▓ Factor experienced by a child or young person who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

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authorities can prevent or reduce suicide by children and young people

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

Child abuse or neglect

Records indicate that, of the 70 children and young people in Group 1:

- 53 were said to have experienced family and domestic violence (76 per cent);

- 31 were recorded as having allegedly experienced sexual abuse (44 per cent);

- 31 were recorded as having allegedly experienced physical abuse (44 per cent);

- 49 were recorded as having allegedly experienced neglect (70 per cent); and

- 27 were recorded as having allegedly experienced other forms of emotional or psychological abuse (39 per cent).

Suicidal ideation and behaviour

Records indicate that, of the 70 children and young people in Group 1:

- 43 demonstrated suicidal ideation (61 per cent);

- 32 communicated their intention to die by suicide to a friend, family member or health professional (46 per cent); and

- 32 had previously attempted suicide (46 per cent).

Mental health issues

Records indicate that, of the 70 children and young people in Group 1:

- 31 self-harmed (44 per cent); and

- 27 were diagnosed with a mental health condition (39 per cent)

Substance use

Records indicate that, of the 70 children and young people in Group 1:

- 39 consumed alcohol at some time in their lives (56 per cent); and

- 34 consumed illicit drugs at some time in their lives (49 per cent).

Adverse family experiences

Records indicate that, of the 70 children and young people in Group 1:

- 28 had a parent with a mental health disorder (40 per cent);

- 36 had a parent who had problematic alcohol and/or other drug use (51 per cent);

- 18 had a parent who was imprisoned (26 per cent); and

- 14 had a family member, friend or person known to them who had died by suicide (20 per cent).

7.3.2 Demographic characteristics

Records indicate that, of the 70 children and young people in Group 1:

- 35 (50 per cent) were male and 35 (50 per cent) were female;

- 37 (53 per cent) were Aboriginal and 33 (47 per cent) were non-Aboriginal;

- 10 were between the ages of 10 and 13 years (14 per cent), 23 were between the ages of 14 and 15 years (33 per cent) and 37 were between the ages of 16 and 17 years (53 per cent); and

- 33 resided in a major city (47 per cent), 15 resided in a regional area (21 per cent), seven resided in a remote area (10 per cent) and 15 lived in a very remote area (21 per cent).

7.4 Young people in Group 2

7.4.1 Factors associated with suicide

The Office identified records indicating that 17 of the 115 children and young people (15 per cent) were diagnosed with one or more mental health condition and/or demonstrated significant planning of their suicide. Seven of these 17 young people (41 per cent) were recorded as having been diagnosed with multiple mental health conditions. Seven (41 per cent) had a parent who had been diagnosed with a mental health condition. None of the 17 young people were recorded as having allegedly experienced any other types of adverse family experiences or any elements of child abuse or neglect (as defined in Figure 79). In this report, this group 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 79.

Figure 79: Factors associated with suicide experienced by the young people in Group 2, by Ombudsman Investigation

Young Person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child maltreatment	Mental health issues
21	X	X	X		X
22	X		X		X
23	X	X			X
24	X				X
25	X		X		
87	X				X
88	X		X		X
89	X		X		
90	X		X		
91	X		X		
92	X				
93					X
94	X				X
95	X				X
96	X	X			X
97			X		
98			X		X

■ Factor experienced by a young person who died by suicide during the 2014 Investigation Period

■ Factor experienced by a young person who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

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

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Suicidal ideation and behaviour	Records indicate that, of the 17 young people in Group 2:
	• 13 (76 per cent) demonstrated suicidal ideation;
	• 4 (24 per cent) communicated their intention to die by suicide to a friend, family member or health professional; and
	• 4 (24 per cent) had previously attempted suicide.
Mental health problems	Records indicate that, of the 17 young people in Group 2:
	• 7 (41 per cent) were living with multiple diagnosed mental health conditions; and
	• 7 (41 per cent) had also self-harmed.
Adverse family experiences	Records indicate that, of the 17 young people in Group 2:
	• 7 (41 per cent) had a parent living with one or more diagnosed mental health conditions; and
	• none had a parent who was imprisoned, a parent who had problematic alcohol or other drug use; and
	• 2 (12 per cent) had a family member, friend or person known to them who had died by suicide.
Substance use	Records indicate that, of the 17 young people in Group 2, four (24 per cent) had consumed alcohol and/or illicit drugs at some time in their lives.
Child abuse or neglect	Records indicate that none of the young people in Group 2 allegedly experienced any child abuse or neglect.

7.4.2 Demographic characteristics

Records indicate that, of the 17 young people in Group 2:

• 4 were female (24 per cent) and 13 were male (76 per cent);

• all 17 were non-Aboriginal;

• their ages ranged from 14 to 17 years; and

• 12 (71 per cent) resided in a major city, four resided in an inner regional area, and one (6 per cent) resided in a remote area.

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7.5   Children and young people in Group 3

7.5.1 Factors associated with suicide

Records indicate that 18 of the 115 children and young people (16 per cent) experienced few factors associated with suicide. Six of the 18 children and young people (33 per cent) who were recorded as having experienced suicidal ideation or behaviour. None were recorded as having experienced adverse family circumstances, any alleged child abuse or neglect or a diagnosed mental health disorder.

However, the Office observed similarities in other characteristics of the 18 children and young people. Records indicate that, all the children and young people were engaged in school and/or involved in a sporting activity. In this report, this group of children and young people is referred to as **Group 3**. The factors associated with suicide experienced by the children and young people in Group 3 are summarised in Figure 80.

Figure 80: Factors associated with suicide experienced by the children and young people in Group 3, by Ombudsman Investigation

Child or Young Person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
27	ORANGE				
31					
28		ORANGE			
26	ORANGE				
29					
30		ORANGE			
99					
100		BLUE			
101					
102	BLUE				
103					
104					
105	BLUE	BLUE			
106					
107	BLUE				BLUE
108					
109	BLUE				
110					

ORANGE   Factor experienced by a young person who died by suicide during the 2014 Investigation Period

BLUE   Factor experienced by a child or young person who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

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

Suicidal ideation and behaviour	Records indicate that, of the 18 children and young people in Group 3, six (33 per cent) demonstrated suicidal ideation and/or their intention to die by suicide to a friend, family member, or health professional.
Substance use	Records indicate that, of the 18 children and young people in Group 3, (17 per cent) had consumed alcohol at some time in their lives.
Child abuse or neglect	Records indicate that none of the children and young people in Group 3 were recorded as having allegedly experienced any child abuse or neglect.
Mental health issues	Records indicate that none of the children and young people in Group 3 had a diagnosed mental health condition or self-harmed prior to their death.
Adverse family experiences	Records indicate that none of the children and 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.

7.5.2   Demographic characteristics

Records indicate that, of the 18 children and young people in Group 3:

- 16 were male (89 per cent), two were female;

- all were non-Aboriginal;

- their ages ranged from 13 to 17 years; and

- 15 resided in a major city (83 per cent), and three (17 per cent) lived in a regional area or very remote area.

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7.6 Young people in Group 4

7.6.1 Factors associated with suicide

Records indicate that, like the young people in Group 3, 10 of the 115 children and young people (9 per cent) experienced few factors associated with suicide. Six of these 10 young people (60 per cent) were recorded as having demonstrated suicidal ideation or behaviour and/or as having engaged in problematic substance use. None were recorded as having experienced adverse family circumstances, alleged child abuse or neglect or as having a diagnosed mental health disorder.

However, the Office observed similarities in the experiences of the 10 young people in this group. Records indicate that all of the young people in Group 4 demonstrated behaviours that could be considered impulsive or risk taking, including:

- substance use;

- recently increased unauthorised absences from school, or 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 group of young people as **Group 4**.

The factors associated with suicide experienced by the young people in Group 4 are summarised in Figure 81.

Figure 81: Factors associated with suicide experienced by the young people in Group 4, by Ombudsman Investigation

Young Person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect
35		■		
36				
32	■	■		
34	■			
33	■	■		
111	■	■		
112				
113				
114				
115		■		

■ Factor experienced by a young person who died by suicide during the 2014 Investigation Period

■ Factor experienced by a young person who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

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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 10 young people in Group 4:
	• 4 (40 per cent) demonstrated suicidal ideation;
	• 4 (40 per cent) communicated their intention to die by suicide to a friend, family member, or health professional; and
	• 3 (30 per cent) had previously attempted suicide.
Substance use	Records indicate that of the 10 young people in Group 4, five (50 per cent) consumed alcohol or illicit drugs at some time in their lives.
Adverse family experiences	Records indicate that none of the young people in Group 4 had a parent living with a mental health condition, 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 abuse or neglect	Records indicate that none of the young people in Group 4 were recorded as having allegedly experienced any elements of child abuse or neglect.
Mental health issues	Records indicate that none of the young people in Group 4 lived with a diagnosed mental health condition or self-harmed prior to their death.

7.6.2 Demographic characteristics

Records indicate that of the 10 young people in Group 4:

• 8 (80 per cent) were male and 2 (20 per cent) were female;

• 5 (50 per cent) were Aboriginal;

• their ages ranged from 14 to 17 years; and

• 6 (60 per cent) resided in a major city, one (10 per cent) resided in a regional area and 3 (30 per cent) resided in a very remote region.

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Figure 82: Summary of the factors associated with suicide, for the 115 children and young people, by group and Ombudsman Investigation

Factors associated with suicide recorded	Group 1			Group 2			Group 3			Group 4		
	2014	2020	2009-10 to 2017-18[510]	2014	2020	2009-10 to 2017-18	2014	2020	2009-10 to 2017-18	2014	2020	2009-10 to 2017-18
Number of children and/or young people												
Children	0	10	10	0	0	0	0	1	1	0	0	0
Young People	20	40	60	5	12	17	6	11	17	5	5	10
TOTAL	**20**	**50**	**70**	**5**	**12**	**17**	**6**	**12**	**18**	**5**	**5**	**10**
Alleged experiences of abuse and/or neglect												
Neglect	12	37	49	0	0	0	0	0	0	0	0	0
Sexual abuse	9	22	31	0	0	0	0	0	0	0	0	0
Exposure to family and domestic violence	17	36	53	0	0	0	0	0	0	0	0	0
Physical abuse	8	23	31	0	0	0	0	0	0	0	0	0
Other emotional or psychological abuse	0	27	27	0	0	0	0	0	0	0	0	0
Mental health issues												
Diagnosed mental health condition	8	19	27	5[511]	7	12	0	0	0	0	0	0
Self-harm	11	20	31	4	3	7	0	1	1	0	0	0
Suicidal ideation and behaviour												
Ideation	13	30	43	5	8	13	2	4	6	3	1	4
Communicated intention to die by suicide	12	20	32	3	1	4	1	0	1	3	1	4
Previously attempted suicide	12	20	32	2	2	4	0	0	0	2	1	3
Adverse family experiences												
Parent with a mental health condition	10	18	28	3	4	7	0	0	0	0	0	0
Problematic parental drug or alcohol use	8	28	36	0	0	0	0	0	0	0	0	0
Parent imprisoned during child or young person's life	5	13	18	0	0	0	0	0	0	0	0	0
Family member, friend or person known to them who had died by suicide	6	8	14	0	2	2	0	0	0	0	0	0
Substance use (lifetime)												
Consumed alcohol	11	28	39	2	1	3	2	1	3	3	1	4
Consumed illicit drugs	9	25	34	1	1	2	0	1	1	1	1	2

Source: Ombudsman Western Australia

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[510] Of children and young people who died between 1 July 2009 and 30 June 2018. The 2014 Investigation period commenced 1 July 2009 for a period of 3.5 years, and the 2020 Investigation period included a 5.5. year period ending 30 June 2018.
[511] Includes young people recorded as having demonstrated significant planning of their death.

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8. Preventing and reducing suicide by children and young people

8.1 Introduction

8.1.1 Early years intervention and trauma-informed prevention

The research literature previously discussed identifies the importance of whole-of-government early intervention strategies in improving the wellbeing of children and young people and reducing the risk of suicidal and self-harming behaviours

The World Health Organization notes that 'protective factors (e.g. connectedness) acquired in childhood may reduce later suicide risk', including the following 'theoretically valid upstream prevention approaches':

> Use of "upstream approaches" such as addressing risk and protective factors early in the life course has the potential to "shift the odds in favour of more adaptive outcomes" over time. Moreover, upstream approaches may simultaneously impact a wide range of health and societal outcomes such as suicide, substance abuse, violence and crime. …
>
> Examples of upstream strategies include:
>
> - Early childhood home visits to provide education by trained staff (e.g. nurses) to low-income expectant/new mothers.
>
> - Mentoring programmes to enhance connectedness between vulnerable young people and supportive, stable and nurturing adults.
>
> - Community-wide prevention systems to empower entire communities to address adolescent health and behaviour problems through a collaborative process of engagement.
>
> - School-based violence prevention and skill-building programmes to engage teachers/staff, students and parents in fostering social responsibility and social-emotional skills-building (e.g. coping, problem-solving skills, help-seeking).[512]

Domestically, the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) has identified the need for:

> … coordination and integration between different areas of the health system (i.e. GPs, public health nurses) and other sectors (i.e. early childhood educations, child support officers) in the early identification of behavioural and emotional disturbances in children, and referral to mental health professionals when appropriate. …
>
> Mental health is an issue for the entire community and requires a whole of community response. Responsibility should sit across portfolios and involve

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[512] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, pp. 44-45

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family and community services, educational institutions, recreation sectors, as
well as consumer and carer groups.[513]

RANZCP has also highlighted the importance of early intervention and prevention strategies
for mental health conditions in infants, children and young people in preventing and reducing
suicidal and self-harming behaviours in children and young people:

> Advances in the science of early childhood and early brain development,
> combined with rigorous program evaluation and research, can provide a strong
> foundation for the development of early intervention and prevention strategies for
> mental illness. Early experiences determine whether a child's developing brain
> architecture provides a strong or weak foundation for all future learning,
> behaviour, and health. Mental health problems during early years can have
> enduring consequences if left unresolved not only by placing individuals at
> increased risk of difficulties in adult life, but also by placing increased pressure
> on limited community service resources. Suffering and negative outcomes can
> also cause intergenerational cycles which become larger problems to address.
> …

> The Royal Australian and New Zealand College of Psychiatrists' (RANZCP)
> Faculty of Child and Adolescent Psychiatrists (FCAP) believes that development
> and implementation of early intervention and prevention strategies for mental
> illness in infants, children and adolescents is imperative to the prevention of
> mental disorder later in life. …

> A developmental perspective is critical to inform prevention, early intervention
> and mental health promotion for infants, children and adolescents. … It is known
> that preventative programs in childhood are effective when they target multiple
> risk factors concurrently and there has been moves, both in Australia and New
> Zealand, to pilot some programs. The priority now is to ensure that such
> programs are properly implemented and evaluated to achieve optimum
> outcomes for childhood mental health.

8.1.2 'Early intervention' refers to interventions taking place during the first 1000 days of a child's development (from conception to their third birthday)

The World Health Organization and the United Nations International Children's Emergency
Fund (UNICEF) have identified in their Nurturing Care Framework for Early Childhood
Development: A framework for helping children survive and thrive to transform health and
human potential that:

> Investing in early childhood development is good for everyone – governments,
> businesses, communities, parents and caregivers, and most of all, babies and
> young children. It is also the right thing to do, helping every child realize the right
> to survive and thrive. And investing in ECD is cost effective: For every $1 spent
> on early childhood development interventions, the return on investment can be
> as high as $13. Early childhood development is also key to upholding the right of
> every child to survive and thrive.

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[513] The Royal Australian and New Zealand College of Psychiatrists, Prevention and Early Intervention of Mental Illness in
Infants, Children and Adolescents: Planning strategies for Australia and New Zealand, Faculty of Child and Adolescent
Psychiatry, RANZCP, Melbourne, 2010, viewed 26 October 2019,
<https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx>, pp. 7, 10.

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We now understand that the period from pregnancy to age 3 is the most critical, when the brain grows faster than at any other time; 80% of a baby's brain is formed by this age. For healthy brain development in these years, children need a safe, secure and loving environment, with the right nutrition and stimulation from their parents or caregivers. This is a window of opportunity to lay a foundation of health and wellbeing whose benefits last a lifetime – and carry into the next generation.

Meanwhile, the cost of inaction is high. Children who do not have the benefit of nurturing care in their earliest years are more likely to encounter learning difficulties in school, in turn reducing their future earnings and impacting the wellbeing and prosperity of their families and societies.[514]

The RANZCP has also relevantly noted that:

Epidemiological studies show a correlation between those who experience psychiatric disorders in childhood and adulthood, with children and young people with conduct disorder at particular risk of developing further mental health problems later in life.

14% of children and adolescents experience mental health problems. Mental illness in infancy, childhood or adolescence can have enduring consequences if left unresolved. Among the many adverse outcomes are reduced self-esteem or confidence, reduced educational and occupational opportunity, increased risk of substance abuse and other mental disorders, as well as increased family conflict, family breakdown and homelessness.

Early intervention strategies targeting the mental health of children, particularly those who have experienced significant trauma and adversity, reduce the likelihood of adverse outcomes in relation to future offending.

The first 1000 days of a child's development (from conception to the end of a child's second year), and the early childhood years can be fundamental to a child's life successes. These early years are a unique period of opportunity when the foundations of optimum health, growth and neurodevelopment across the lifespan are developed. Many challenges faced by adults, such as mental health issues, obesity, heart disease, criminality, and poor literacy and numeracy, can be traced back to pathways that originated in early childhood.

Early intervention programs should focus on early childhood and the first 1000 days, with a focus on assisting new parents, families and schools.[515]

8.1.3 Suicide prevention and promoting healthy development during middle childhood and adolescence

The need to implement interventions that aim to improve the mental health of all children and young people (i.e. universal prevention strategies) in addition to targeted interventions for children and young people at risk of suicide has also been recognised by Orygen, the

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[514] World Health Organization, United Nations Children's Fund, World Bank Group, Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential, WHO, Geneva, 2018, p. 1.

[515] Royal Australian and New Zealand College of Psychiatrists, *Submission to the Legal and Social Issues Committee's Inquiry into youth justice centres in Victoria,* 21 September 2018, viewed 26 October 2019, <https://www.ranzcp.org/files/resources/submissions/ranzcp-qld-submission-on-youth-justice-strategy-se.aspx>, p. 2.

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National Centre of Excellence in Youth Mental Health, who concluded in their 2016 report *Looking the other way: Young people and self-harm* that:

> … the complex nature of suicide related behaviours and self-harm requires the inclusion of interventions that have a broader focus than self-harm alone. They argue that interventions solely attempting to reduce the behaviour may not always be appropriate (or acceptable) to participants, and that interventions that aim to improve protective factors (such as monitoring of risks and provision of parental support) might be effective in reducing the risk of self-harm and suicide-related behaviours.

> They reviewed a number of interventions that ranged from: very brief individual therapy, to group interventions, family interventions, treatments that integrate assertive case management with individual psychotherapy, Cognitive Analytic Therapy (CAT) and intensive individual treatments (such as MBT-A).

> Despite the limitations of these studies (e.g., differing definitions of self-harm and relatively small sample sizes) they were able to draw some conclusions. Firstly, brief interventions can improve engagement in further treatment by young people with suicidal ideation, which might go on to reduce subsequent risk of self-harm. Secondly, treatments that included family involvement or increased support appeared to show promise in reducing the risk of self-harm.

> As such, there has been an increasing focus on the development of high quality simpler treatments. In BPD populations (both adult and adolescent) psychosocial therapies which involve a structured (manual directed) partnership between patients and clinicians who are well supervised, responsive and validating, show promise. Good Clinical Care (GCC), a high quality, manualised treatment that forms the basis of the early intervention for BPD program Helping Young People Early (HYPE), and has also been demonstrated to reduce self-harm and suicide-related behaviour almost as well as the specialised treatment it was compared to.[516]

However, the evidence base for suicide and self-harm prevention interventions for children and young people is limited, particularly in Australia where access to timely population data is difficult and contracting of health and social services is often output based, rather than outcomes based.

8.1.3.1   Universal interventions

An analysis conducted by Orygen found moderate benefits from universal awareness campaigns and gatekeeper training programs with identifiable pathways to referrals and treatment, and that that universal school based programs 'based on behavioural change were found to be effective [and] … associated with significant reductions across a variety of suicide-related behaviours'.[517] Culturally, community-led suicide prevention responses were also noted by Orygen as having 'demonstrated efficacy … [in] providing community

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[516] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 43.
[517] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 43.

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members with coping strategies within a culturally responsive and supportive framework'
and 'significant[ly] decreas[ing] … suicide rates'.[518]

8.1.3.2   Selective interventions for at-risk groups

The research literature includes some evidence supporting selective interventions for at-risk
groups of children and young people, such as: activities to strengthen community and
environmental supports; postvention supports for those bereaved by suicide;[519] and
enhanced prevention in places or communities with high rates of suicide, self-harm and child
abuse or neglect.

Programs promoting the safety, wellbeing and resilience of vulnerable children and young
people, such as parenting programs aimed at enhancing 'adaptive parent-child relationships
and behaviours can protect against negative developmental trajectories [including
suicide].'[520]

Significantly, the research literature identifies that, 'despite a great deal of evidence …
clearly demonstrating that [exposure to] parental suicidal behaviour may be a significant risk
factor' for suicide by children and young people, postvention studies are 'lacking' for this
cohort.[521] However, recent interventions 'targeted at improving attachment and familial
management, as well as reducing the environmental exposure of risk factors [such as
neglect and sexual abuse]'[522] for children and young people whose parents have attempted
suicide have shown 'promising results'.

A similar gap in evidence exists regarding the efficacy of suicide prevention interventions for
children and young people who have experienced multiple traumas, such as multi-type
abuse and poly-victimisation. The American Psychological Association[523] has noted that:

- 'a substantial minority of [such] children [and young people] develop acute or ongoing
  psychological symptoms (including PTSD …)';

- most 'are not identified and consequently do not receive any help'; and

- 'Even when children are seen for mental health services, their trauma exposure may not
  be known or addressed. For those children who do receive services, evidence-based
  treatment is not the norm. … Although behavioral problems are readily noticed by
  parents and teachers, children's anxiety and depressive symptoms are not.'

The research literature also identifies that trauma-informed treatment for children and young
people who have been exposed to traumatic events is not amenable to a one-size fits all
approach, with a need 'to differentiate between universal assistance that is likely to be useful

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[518] Robinson J et al, *Looking the Other Way: Young people and self-harm,* Orygen, The National Centre of Excellence in
Youth Mental Health, Melbourne, 2016, p. 43.
[519] J Robinson et al, Raising the bar for youth suicide prevention: Appendix 1 – Evidence review youth suicide
prevention (2016), Orgyen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.
[520] Lunde I et al, 'Systematic Literature Review of Attempted Suicide and Offspring', *International Journal of
Environmental Research and Public Health,* vol. 15, no. 5, May 2018, p. 937, doi: 10.3390/ijerph15050937.
[521] Lunde I et al, 'Systematic Literature Review of Attempted Suicide and Offspring', *International Journal of
Environmental Research and Public Health,* vol. 15, no. 5, May 2018, p. 937, doi: 10.3390/ijerph15050937.
[522] Lunde I et al, 'Systematic Literature Review of Attempted Suicide and Offspring', *International Journal of
Environmental Research and Public Health,* vol. 15, no. 5, May 2018, p. 937, doi: 10.3390/ijerph15050937.
[523] American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in
Children and Adolescents, *Children and Trauma: Update for Mental Health Professionals*, American Psychological
Association,, Washington DC, 2008, pp. 3-4.

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to all trauma-exposed children and families (e.g., basic information on what to expect, support for existing coping resources) and targeted interventions that are appropriate only for those with demonstrated need (e.g. formal psychological intervention).'[524]

8.1.3.3   Indicated clinical interventions for at risk individuals

The research literature identifies evidence supporting the use of indicated clinical interventions for children and young people at high risk of suicide, including assertive follow-up after a suicide attempt and pro-actively managed transitions to community care after hospital treatment. It also notes the importance of child-centred services and working flexibly to support individual children and young people at risk of suicide, such as 'keep[ing] doors to treatment open'[525] ensuring '24/7 availability' and undertaking 'assertive outreach'[526] to connect and engage with children, young people, families and communities.

In particular, the research literature highlights the importance of targeted prevention efforts for children and young people upon discharge from hospital after a suicide attempt, a time of critical risk when an out of hours and/or rapid response may be required[527] and that:

> … hospitalized adolescents should get a "front loading" of treatment, since the risk of recurrence [of attempted suicide] is highest right after discharge.[528]

There is also evidence supporting the efficacy of Emergency Department Counselling on Access to Lethal Means (known as **ED CALM**) for parents of children and young people who have attempted suicide, including the provision of safe storage boxes for medications and firearms, to reducing children and young people's access to lethal means.[529]

The research literature further identifies that psychosocial interventions targeted at promoting the general wellbeing of adolescents may also be effective in reducing adolescent suicidal ideation, suicide attempts, or self-harm, such as those that:

> … focus on the augmentation of protective factors, such as parent support and positive affect, as well as the promotion of sobriety and healthy sleep.[530]

Other evidence indicates the effectiveness of telephone counselling, cognitive behavioural therapy, family interventions, dialectical behavioural therapy, multi-modal pharmacological intervention in for outpatients and other children and young people in the community identified as being at risk of suicide.[531] Online cognitive behavioural therapy delivered in

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[524] American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, *Children and Trauma: Update for Mental Health Professionals*, American Psychological Association,, Washington DC, 2008, pp. 4-5.

[525] American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, *Children and Trauma: Update for Mental Health Professionals*, American Psychological Association,, Washington DC, 2008, p. 5.

[526] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 3

[527] Dudgeon P et al, Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report, School of Indigenous Studies, UWA, November 2016, p. 3.

[528] Brent, David A et al. "Protecting adolescents from self-harm: a critical review of intervention studies." *Journal of the American Academy of Child and Adolescent Psychiatry* vol. 52,12 (2013): 1260-71. doi:10.1016/j.jaac.2013.09.009.

[529] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, Centres for Disease Control and Prevention, Atlanta Georgia, 2017, p. 25.

[530] Brent, David A et al. "Protecting adolescents from self-harm: a critical review of intervention studies." *Journal of the American Academy of Child and Adolescent Psychiatry* vol. 52,12 (2013): 1260-71. doi:10.1016/j.jaac.2013.09.009.

[531] J Robinson et al, Raising the bar for youth suicide prevention: Appendix 1 – Evidence review youth suicide prevention (2016), Orgyen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

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secondary schools has also shown effectiveness in significantly decreasing levels of suicidal ideation and promoting help-seeking behaviour in adolescents.[532]

In hospital settings, there is evidence supporting the use of problem-solving, multi-modal and psychological interventions (mode deactivation therapy and dialectical behavioural therapy) in both emergency departments and inpatient facilities.[533]

8.1.4 The role of State government departments and authorities

In the 2014 Investigation, the Office noted that the patterns identified during the course of that investigation may have implications for Western Australia, in particular that:

- different suicide prevention activities may be relevant to each of the four groups of children and young people who died by suicide;

- preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child abuse or neglect and mental health issues;

- State government departments and authorities have and important role to play in preventing suicide by young people, including the Department of Health, the Department of Communities and the Department of Education;

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

- sharing information to effectively identify children and young people at risk of suicide and inter-agency collaboration to prevent and reduce suicide by children and young people who experience multiple risk factors and are known to multiple State Government departments is of importance.

8.1.5 Investigations and reports published by Child Death Review bodies in other Australian State jurisdictions since the 2014 Investigation

Since the 2014 Investigation, several reports about suicide by children and young people have been published by other Australian Child Death Review Teams, including in Queensland, New South Wales and South Australia.

8.1.5.1 Queensland

In 2015-16, the Queensland Child and Family Commission (**QFCC**) used an online survey to consult '472 children and young people who had thought about, planned or attempted suicide … [about] their experiences of seeking and getting support'.[534] The results of this survey indicated that:

> Young people don't seek help due to shame and fear of being 'judged' or labelled
> an 'attention seeker', but most are hoping someone will 'see through their smile'

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[532] J Robinson et al, 'Can an internet-based intervention reduce suicidal ideation, depression and hopelessness among secondary school students: Results from a pilot study,' *Early Intervention in Psychiatry*, 10(1), 28-35

[533] J Robinson et al, Raising the bar for youth suicide prevention: Appendix 1 – Evidence review youth suicide prevention (2016), Orgyen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

[534] Scott J et al, *Research Summary: Suicide in children and adolescents in Queensland 2004-2015*, Queensland Family & Child Commission, viewed 26 October 2019, <https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/research/research-summaries/research-summary-suicide-of-young-people-in-Queensland.pdf>.

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and reach out to help them. Unfortunately, many survey respondents found that others expressed judgemental attitudes, trivialised their feelings, and in fact accused them of attention-seeking. This had serious consequences such as increasing distress and isolation, and delaying further help-seeking by years.

Across a range of support sources, young people found counsellors and psychologists most helpful, while medical professionals and parents were least helpful.

What mattered most to young people was a relationship with someone who genuinely cared, listened without judging and made them feel valued and important.[535]

The QFCC concluded that the following strategies may improve service responses for children and young people who had thought about or attempted suicide:

- Children and young people with lived experience have unique perspectives; including their voices can enhance policy and practice responses.
- Youth specialist services, with counsellors trained and experienced to connect with young people are needed.
- Community-wide education is needed to ensure children receive an appropriate response regardless of where they turn for help.
- Families/parents need both education and support.
- Services need to be easily accessible, particularly for young people who lack parental support.
- Service delivery needs to be underpinned by a caring relationship, actively demonstrated to the young person.
- Young people would benefit from emergency responses that do not involve police and avoid hospital admission as much as possible.
- Additional services for children under 12 years without a diagnosable mental illness are needed.[536]

A ten-year review of children and young people who died by suicide in Queensland subsequently found that:

- Males, Indigenous Australians and young people who have had contact with child safety are at higher risk of dying by suicide.
- Most suicides cannot be predicted. Only half of young people who died by suicide expressed suicidal ideation in the time before their death.
- Most people die by methods for which access cannot be restricted.
- Factors which made young people more vulnerable to suicide included exposure to maltreatment, family violence and parental maladjustment and bullying.
- The most common recent triggers for suicide included conflict with parents, friends, partners and siblings.
- Suicide prevention involves increasing young people's connectedness to their communities and ensuring they can access support when distressed.

[535] Scott J et al, *Research Summary: Suicide in children and adolescents in Queensland 2004-2015*, Queensland Family & Child Commission, viewed 26 October 2019, <https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/rese arch/research-summaries/research-summary-suicide-of-young-people-in-Queensland.pdf>, p. 1.

[536] Scott J et al, *Research Summary: Suicide in children and adolescents in Queensland 2004-2015*, Queensland Family & Child Commission, viewed 26 October 2019, <https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/rese arch/research-summaries/research-summary-suicide-of-young-people-in-Queensland.pdf>, p. 2.

- Suicide occurs in young people with and without mental illness and the risk factors for suicide are the same risk factors for other physical and mental health and social problems throughout life.[537]

The QFCC researchers recommended the following 'steps … society [should] take to prevent young people from dying of suicide':

> A combination of universal, selective and targeted prevention and intervention strategies are needed that improve the health of all young people …
>
> **Universal strategies**
>
> - Parenting skills training (e.g. Triple P)
> - Bullying prevention programmes
> - Mental health first aid training for parents and teachers
>
> Similarly, universal strategies to improve mental health need to be affordable, acceptable and feasible to deliver. The widespread adoption of any intervention will likely require some form of incentivisation. Otherwise, disadvantaged families are at greater risk of not accessing the interventions because of difficulties with resources.
>
> Equally important are increasing young people's sense of connectedness and belonging. This requires fostering stronger communities at home and at school and developing cultures of inclusiveness and acceptance.
>
> **Targeted strategies**
>
> Services (e.g. Kids Helpline and headspace) are available for young Queenslanders with mental health problems. Improving access and reducing stigma are necessary to ensure young [people] … access assistance early.
>
> A coordinated response is urgently needed to improve the mental health and wellbeing of young people … Reducing suicides requires interventions for families, schools and online activity [original emphasis].[538]

8.1.5.2   *New South Wales*

As noted in the 2014 Investigation, the New South Wales Child Death Review Team's (**CDRT**) reports on suicide by children and young people in New South Wales have identified the following patterns and trends in the nature and extent of identified risks and agency contact:

> Recognising the multi-factorial nature of suicide risk, and that the presence of risk factors is not predictive of suicide, our reports have noted that the degree to which the young people were identified to be at risk before they died was along a continuum, ranging from those for whom concerns about suicide risk where

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[537] Scott J et al, *Research Summary: Suicide in children and adolescents in Queensland 2004-2015*, Queensland Family & Child Commission, viewed 26 October 2019, <https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/rese arch/research-summaries/research-summary-suicide-of-young-people-in-Queensland.pdf>, pp. 1-2.

[538] Scott J et al, *Research Summary: Suicide in children and adolescents in Queensland 2004-2015*, Queensland Family & Child Commission, viewed 26 October 2019, <https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/rese arch/research-summaries/research-summary-suicide-of-young-people-in-Queensland.pdf>, p. 2.

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clearly apparent to those who were not on the radar of services or practitioners as being at risk or needing help.

- **Young people with serious ongoing difficulties, complex needs and a clearly identified risk of suicide:** Some young people had a lengthy child protection history, difficulties with educational engagement, diagnosed mental illness, selfharming and suicidal behaviour and hospital admissions as a result of self harm and/or acute mental illness. In many of these cases, the young person was receiving extensive support from a range of agencies. Other young people refused to engage with therapeutic supports and/or were non-compliant with treatment regimes.
- **Young people with some identified coping difficulties or challenges, but not considered to be at risk of suicide:** Some young people attended school regularly with no or few issues identified in relation to behaviour or academic performance, but had been identified as requiring support for mental health concerns, often depression and/or anxiety. Mostly, this group of young people were reported as responding well to counselling or other treatment, and had disclosed no history of suicidal thoughts or self-harming behaviours.
- **Young people for whom there were no evident indicators that they required support or assistance:** Some young people were reported to have attended school regularly and participated in social and other activities outside of school with no issues identified. Most often, these young people had not previously exhibited symptoms of mental ill-health and no or few concerns had been identified in relation to behaviour prior to death. In some cases, post-death inquiries identified that the young person may have been struggling with depressed mood or other difficulties, however, had not disclosed this to anyone.[539]

In its submission to the recent Parliament of New South Wales Joint Committee on Children and Young People's inquiry into the prevention of youth suicide, the CDRT relevantly observed that health, education and child protection services are the key State government departments and authorities with functions relating to children and young people at risk of suicide:

In relation to youth suicide, we note that there are a broad range of government and non-government agencies in New South Wales with roles and responsibilities relating to the support of children and young people at risk, including in relation to the provision of:

- … Health services, including acute, community based, and specialist adolescent mental health programs and services e.g. CAMHS.
- Commonwealth services, including those targeted to youth mental health e.g. Headspace.
- Education services, including school counsellors, welfare programs and postvention supports in schools.

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[539] Wolf M, Child Death Review Team, NSW Ombudsman, Submission No. 45 to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW, August 2017, viewed 26 October 2019, <https://www.parliament.nsw.gov.au/ladocs/submissions/58726/Submission%2045%20-%20Child%20Death%20Review%20Team,%20NSW%20Ombudsman.PDF>, pp. 8-9.

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- Child protection services, including responsibility for responding to risk of significant harm, reports about self-harm and suicidal behaviours, and for the health and wellbeing of young people in the care of the Minister.

In this context, we consider that a focused whole-of-government approach to suicide prevention is warranted.[540]

Similar to the 2014 Investigation, the CDRT identified opportunities to improve suicide prevention activities through collaboration between health, mental health, education and child protection services, including:

- The importance of providing multiple avenues and opportunities for young people to obtain help
- The importance of early identification, and response to, mental health concerns, including:
  - the need for appropriate referral, assessment and therapeutic support for young people identified to be at risk of suicide
  - the need for proactive follow-up of young people who present to health services for assistance
  - strategies for assertive follow up in circumstances where there is lack of follow-through by families or the young person expresses reluctance to engage with therapeutic supports
- The key role of schools in supporting students at risk, including in relation to:
  - working with families to facilitate referrals to specialist mental health services, and supporting young people to manage risks in the school environment
  - the provision of postvention supports and strategies targeted to young people who have experienced the suicide death of another student, family member or friend
  - de-stigmatising mental health problems through whole-of-school programs designed to promote mental health and wellbeing
- The need to ensure coordination of care and support provided to young people at risk
- That young people in out-of-home care are particularly vulnerable and often experience significant risk factors and unmet need
- The need for an overarching whole-of-government suicide prevention framework that includes a specific focus on measures targeted towards the particular needs of children and young people
- The importance of measuring and evaluating the impact of suicide prevention strategies and initiatives
- The need for effective data collection and reporting on youth suicide[541]

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[540] Wolf M, Child Death Review Team, NSW Ombudsman, Submission No. 45 to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW, August 2017, viewed 26 October 2019, <https://www.parliament.nsw.gov.au/ladocs/submissions/58726/Submission%2045%20-%20Child%20Death%20Review%20Team,%20NSW%20Ombudsman.PDF>, pp 14–15.

[541] Wolf M, Child Death Review Team, NSW Ombudsman, Submission No. 45 to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW, August 2017, viewed 26 October 2019,
<https://www.parliament.nsw.gov.au/ladocs/submissions/58726/Submission%2045%20-%20Child%20Death%20Review%20Team,%20NSW%20Ombudsman.PDF>, pp. 9-10.

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8.1.5.3   South Australia

The South Australian Child Death and Serious Injury Review Committee (**CDSIRC**) utilises a similar 'life chart analysis' approach to reviewing the deaths of 49 children and young people who died by suicide in South Australia since 2005. The publication of their 2018 findings in relation to these 49 children and young people also identified four distinct groups of children and young people who died by suicide, as follows:

> **Group 1**
> Intervention and prevention strategies need to begin early in life for young people who have disengaged from home, school, community and other forms of support.
>
> **Group 2**
> Youth-oriented mental health services are needed by young people who experience anxiety, depression and other emerging mental health issues in their teenage years.
>
> **Group 3**
> Readily available support and information services are needed by young people who have no identifiable risk factors, and are not involved with support services.
>
> **Group 4**
> The Committee does not have enough information about the three young people in Group 4 to determine common themes in their lives. More analysis may be possible in time, should further cases be added to this grouping.[542]

The CDSIRC identified the need for suicide prevention efforts to recognise that the children and young people who die by suicide are not a homogenous group.[543] It also noted that 'suicide prevention plans focused on risk factors, tipping points and imminent harm' may not include effective suicide prevention activities for children and young people with 'multiple and complex problems starting very early in life' presenting as 'social and educational disengagement [and] involvement of educational support services, child protection, juvenile justice, adolescent mental health, housing, and drug and alcohol services'.[544]

Like the 2014 Investigation, the CDSIRC recommended differentiated suicide prevention activities to meet the needs of the children and young people in Groups 1 to 3 as those proposed by the Office in the 2014 Investigation, as summarised in Figure 83:

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[542] Government of South Australia, Child Death and Serious Inquiry Review Committee, *Suicide Prevention and Child Death Review*, 10 October 2018, viewed 26 October 2019, <http://www.cdsirc.sa.gov.au/>.
[543] Government of South Australia, Child Death and Serious Inquiry Review Committee, *Suicide Prevention and Child Death Review*, 10 October 2018, viewed 26 October 2019, <http://www.cdsirc.sa.gov.au/>.
[544] Government of South Australia, Child Death and Serious Inquiry Review Committee, *Suicide Prevention and Child Death Review*, 10 October 2018, viewed 26 October 2019, <http://www.cdsirc.sa.gov.au/>.

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Figure 83: Findings of the South Australian CDSIRC

Group	Themes Identified	Proposed intervention and prevention strategies
1	▪ Multiple and complex problems starting very early in life, including significant family upheaval often resulting in homelessness. ▪ Learning and behavioural problems which often started at kindergarten. ▪ Exacerbation of these problems in adolescence, including problems making and keeping friends – leading to social and educational disengagement. ▪ Involvement of educational support services, child protection, juvenile justice, adolescent mental health, housing, and drug and alcohol services.	▪ Strengthening parenting capacity within families during the child's very early years. ▪ Addressing learning and behavioural problems, as they are identified in early childhood. ▪ Ensuring that ongoing problems with learning and social skills are addressed, with every effort made to keep the young person engaged in education, especially in the transition to secondary school and throughout adolescence. ▪ Promoting engagement through youth-specific programs in the community, with a focus on building resilience and restoring self-esteem. ▪ Ensuring integrated service delivery – juvenile justice, drug and alcohol services, mental health services and alternative education options.
2	▪ The presence of a supportive family or family member. ▪ Engagement with family, school and friends until the emergence of challenges to their mental health, e.g depression and/or anxiety, which often occurred after their transition to secondary school. ▪ Seeking help from adolescent mental health services (government or private), and requiring assertive outreach. ▪ History of deliberate self-harm and/or previous suicide attempts. ▪ Challenges in social, romantic or sexual relationships in the year/months proximal to their death.	▪ Provision of youth-oriented mental health services with an emphasis on assertive outreach and follow-up, and the capacity to support the young person's family. ▪ Co-ordination between mental health services and school support services. ▪ Youth-specific services with the capacity to explore issues relating to romantic and sexual relationships.
3	▪ Stability at home, in friendships and at school. ▪ 'Positive' approaches to life. ▪ Exposure to suicide through school connections. ▪ No contact with support services. ▪ Challenges in romantic/sexual or social relationships immediately proximal to their death.	▪ Readily available and accessible support and information sources – through school, workplace and/or community as well as 'crisis' support, especially access to help for young people during the critical hours when they appear to decide to suicide. ▪ Population-based prevention programs that emphasise the role that friends/peers play in helping those who are contemplating suicide.

Source: Child Death and Serious Injury Review Committee (2018)

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8.2 Patterns and trends in contact between the children and young people who died by suicide and public health services

8.2.1 The 2014 Investigation

In the 2014 Investigation, the Office identified that the patterns and trends in the factors associated with suicide and contact with Child and Adolescent Mental Health Services experienced by the 36 young people who died by suicide may have implications for the Department of Health. In particular, the Office considered the Department of Health's *Clinical Risk Assessment and Management in Western Australian Mental Health Service: Policy and Standards* (**the CRAM Policy**) noted that:

- 12 of the 36 young people were recorded as having lived with one or more mental health conditions and all were referred for assessment by the Child and Adolescent Mental Health Service at some point in their lives;

- 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;

- 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; and

- the findings of the 2014 Investigation with respect to Aboriginal young people supported the recommendations of the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*. Namely that the Department of Health 'continues 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'.

8.2.2 Developments since the 2014 Investigation

Previously, responsibility for the delivery of health services was located centrally, vested in the Director General of the Department of Health, pursuant to the *Hospitals and Health Services Act 1927*.

Since the 2014 Investigation, significant legislative, policy and structural reform has occurred in the Western Australian public health system.

On 30 November 2015 the new *Mental Health Act 2014* commenced into effect, replacing the former *Mental Health Act 1996* with modern mental health legislation. The objects of the *Mental Health Act 2014* are set out in section 10 as follows:

> (a) to ensure people who have a mental illness are provided the best possible treatment and care:
>
> > (i) with the least possible restriction of their freedom; and
> >
> > (ii) with the least possible interference with their rights; and
> >
> > (iii) with respect for their dignity;

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(b) to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;

(c) to recognise and facilitate the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options that are available for their treatment and care;

(d) to help minimise the effect of mental illness on family life;

(e) to ensure the protection of people who have or may have a mental illness;

(f) to ensure the protection of the community.

On 1 July 2016, the *Hospitals and Health Services Act 1927* was replaced by the *Health Services Act 2016*, which, according to the Department of Health:

- reshaped the role of the Department of Health as 'system manager',[545] with responsibility for strategic planning, safety and quality monitoring, system-wide industrial relations, contracting with health entities and entering into service agreements with health service providers; and

- established five new Health Service Providers as separate statutory authorities, each of which is 'legally responsible for the delivery of health services for their local areas and communities'.[546]

Collectively, the separate entities now operating as part of the Western Australian public health system are known as **WA Health**.

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[545] Department of Health, *Health Reform Fact Sheet: The Role of the Department of Health*, Government of Western Australia, Perth, 2016, viewed 9 September 2018, <https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Reform/The-Role-of-the-Department-of-Health-Fact-Sheet.pdf>, p. 1.
[546] Department of Health, *Health Reform Fact Sheet: The Health Services Act 2016: A Snapshot,* Government of Western Australia, Perth, 2016, viewed 9 September 2018, <https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Reform/Fact%20Sheet%20-%20The%20Health%20Services%20Act%202016%20-%20Snapshot.pdf>, p. 2.

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Figure 84: WA Health Structure
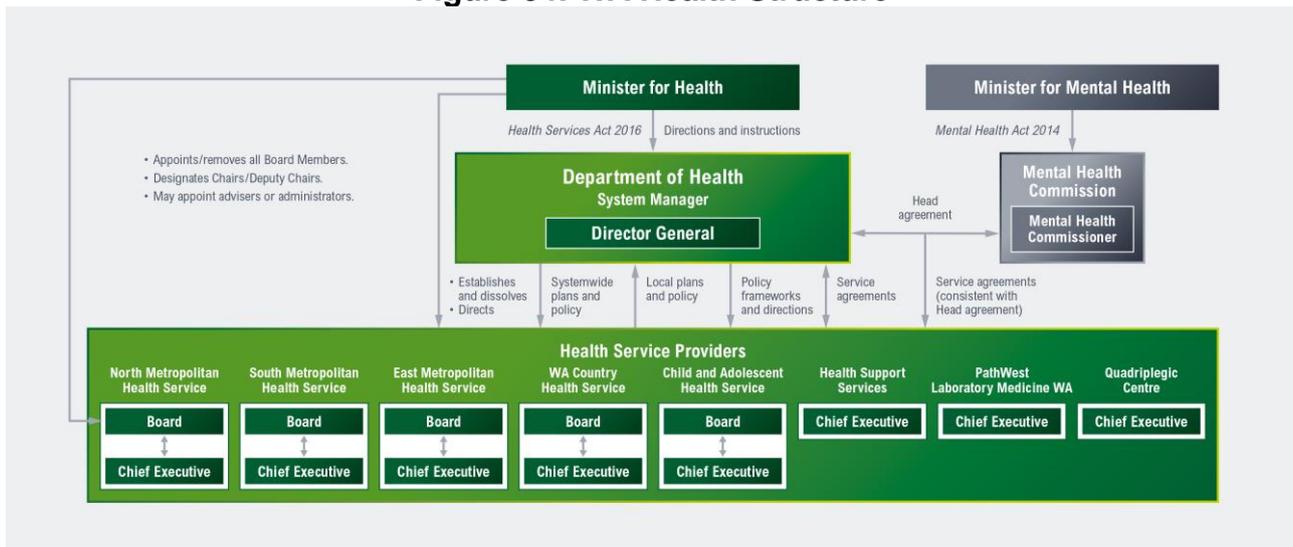
Source: Department of Health[547]

As a result of these changes, the former 'CAMHS' considered in the 2014 Investigation has transitioned from being part of the Department of Health to part of the new, stand alone Child and Adolescent Health Service (**CAHS**). However, Child and Adolescent Mental Health Services (that is, public mental health care for children and young people) are provided by both CAHS and the Western Australian Country Health Service (**WACHS**).[548]

According to CAHS, it 'provides a comprehensive service supporting the health, wellbeing and development of young Western Australians'[549] through three service directorates:

- Child and Adolescent Health Service - Community Health (known as Child and Adolescent Community Health (**CACH**) prior to 1 July 2018);

- Child and Adolescent Health Service – Child and Adolescent Mental Health Services (**CAHS CAMHS**); and

- Perth Children's Hospital.

CAHS provides both inpatient and community based mental health services for children and young people. The CAHS Perth Children's Hospital is commissioned to provide a 20-bed inpatient mental health unit for children and young people up to 16 years, and is also the location of the following specialist services:

- **Mental Health Inpatient Unit**, Ward 5A. WA's only Authorised Mental Health Inpatient Unit for patients aged 0-16.

- **Statewide Eating Disorder Service**, which provides an outpatient and day program for children and young people with eating disorders.

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[547] Department of Health, *WA Health Structure*, Government of Western Australia, Perth, viewed 15 February 2020, <https://ww2.health.wa.gov.au/~/media/Images/Corporate/About%20us/WA-Health-Structure.jpg>.
[548] Both health service providers were established under clause 12(1) of the *Health Services (Health Service Providers) Order 2016* as published in the Government Gazette dated 17 June 2016.
[549] Government of Western Australia Department of Health, *Child and Adolescent Health Service*, Government of Western Australia, Perth, 2018, viewed 9 September 2018, <https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service>.

- **Statewide Gender Diversity Service**, which provides assessment, care and treatment of gender diversity related issues, including assessment and approval for medical intervention in teenagers;[550]

- **Paediatric Consultation Liaison**, which provides support for children and adolescents who are patients at Perth Children's Hospital and have mental health issues relating to their medical conditions or their treatment plan;[551] and

- **Mental Health Support Line**.

There are 10 Community CAHS Child and Adolescent Mental Health Services (known as **CAMHS**) sites across the metropolitan area: Armadale, Bentley Family Clinic, Clarkson, Fremantle, Hillarys, Peel, Rockingham, Shenton, Swan and Warwick. These services are commissioned to provide services to children and young people up to the age of 18 years.

- **Pathways** – a day program for children aged 6 to 12. Pathways Therapeutic Day Program is an evidence-based Tier 4 service providing educational and therapeutic services in an integrated manner to children with complex educational, social behavioural, emotional and mental health issues. Referrals come from Tier 3 services such as [Community] CAMHS, Child Development Services and other specialised health services for children.

- **Touchstone** – a day program for adolescents aged 12-17 and their families. The therapy program offers an evidence-based intervention to help young people that are struggling to cope with relationships, mood difficulties and impulsive self-harming behaviours such as cutting.

- **Multisystemic Therapy** – for children aged 12-16 with anger, violence and/or antisocial behaviour. May have co-morbid alcohol and other drug use and issues with school or employment due to behaviour.

WACHS provides community based CAMHS in each of its seven regions, including two small specialist youth mental health services, funded by the Mental Health Commission. However, in rural and remote areas there are no inpatient facilities for children and young people. Accordingly, WACHS provides only community based mental health services for children and young people.

In this report, the mental health services provided by CAHS and WACHS to children and young people will be referred to, respectively, as **CAHS CAMHS** and **WACHS CAMHS**.

Additional specialist 'youth mental health' inpatient units for young people and young adults ages 16-24 years are operated by the East Metropolitan and South Metropolitan Health Services, but these health service providers do not have any corresponding youth mental health community services.

The North Metropolitan Health Service also has a Youth 'Hospital in the Home' for 16-24 year olds as part of its Youth Mental Health Program (which also includes YouthLink,

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[550] Department of Health, *Child and Adolescent Health Service – Mental Health PCH Mental Health*, CAHS, Perth, viewed 9 September 2018, <https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Mental-Health-Service/Our-services/PCH-Mental-Health>.

[551] Department of Health, *Child and Adolescent Health Service – Mental Health PCH Mental Health*, CAHS, Perth, viewed 9 September 2018, <https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Mental-Health-Service/Our-services/PCH-Mental-Health>.

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YouthReach South, YouthAxis, Youth and Adult Complex Attentional Disorders Service and a Gender Pathways Service).

Under sections 26 and 27 of the *Health Services Act*, all Health Service Providers, including CAHS CAMHS and WACHS CAMHS are required to comply with the Department of Health's *Mental Health Policy Framework*, which includes the CRAM policy considered in the 2014 Investigation, and the new *Clinical Care of People Who May Be Suicidal Policy*.[552]

The *Clinical Care of People Who May Be Suicidal Policy*, effective since 13 December 2017, guides:

> … providers of mental health care in the development of procedures to support the provision of evidence-informed clinical care for people at risk of suicide, aimed at maximising their safety and supporting their recovery. It signals a shift in policy from an emphasis on risk to one of safety and recovery.[553]

This policy also requires health service providers to develop a local policy that aligns to the *Principles and Best Practice for the Clinical Care of People Who May Be Suicidal*. A number of the key factors associated with suicide identified in the 2014 Investigation, including childhood abuse or neglect and other adverse family circumstances, are highlighted as part of a 'best practice' approach to assessing and caring for those who may be suicidal:

> Assessment must be conducted in collaboration with the individual and where possible and appropriate their family and personal support person and is to encompass:
>
> a) a detailed evaluation of all aspects of suicidal behaviour and ideation;
>
> b) a psychiatric diagnostic assessment and formulation; and
>
> c) a thorough determination of the psychosocial circumstances contributing to the clinical presentation. In the case of children and adolescents, this involves assessment of parents'/guardians' ability to safeguard their child and contain risk.
>
> …
>
> People experiencing recurrent or persistent suicidal ideation and those making multiple suicide attempts and/or multiple occasions of self-harm have an underlying heightened baseline risk of suicide associated with the presence of long-term static and historical predisposing factors (e.g. gender, childhood adversity, family history of suicide, repeated self-harm or mental illness). It is upon this base of long-term heightened propensity for suicide that the dynamic risk factors (e.g. psychosocial stressors, a sense of hopelessness, non-adherence to treatment, hospital admission / discharge), which fluctuate in duration and intensity, build and can rapidly tip the person over into an episode of suicidal or self-harming behaviour.

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[552] Department of Health, *Mental Health Policy Framework*, Government of Western Australia, Perth, 2018, viewed 9 September 2018 <http://www.health.wa.gov.au/circularsnew/frameworks/Mental_Health.pdf>, p. 2.
[553] Department of Health, *Clinical Care of People Who May Be Suicidal Policy*, Government of Western Australia, Perth, 2017, viewed 9 September 2018, <http://www.health.wa.gov.au/circularsnew/pdfs/13383.pdf>, p. 1.

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On-going assessment of these dynamic risk factors and their complex interaction with longer term pre-disposing factors, as well as the capacity of the individual and their support network is critical for informing the person's clinical care.[554]

8.2.2.1 Role of the Chief Psychiatrist

Under section 515(1)(a) and (b) of the *Mental Health Act 2014*, the Chief Psychiatrist is responsible for overseeing the treatment and care of all voluntary patients being provided with treatment or care by a mental health service and all involuntary patients. The Chief Psychiatrist discharges this responsibility by publishing standards for treatment and care and overseeing compliance with those standards, in accordance with section 515(2) of the *Mental Health Act 2014*.[555]

In November 2015, the *Chief Psychiatrist's Standards for Clinical Care* were published as required under section 547(2) of the *Mental Health Act 2014,* including a *Standard: Risk Assessment and Management*, which provides a set of definitions, contextual statements and criteria to 'assess, minimise and manage the risks in relation to risk to self, to others and from others' that may arise in the course of mental health service provision.

The Chief Psychiatrist's *Standard: Risk Assessment and Management* applies to all public and private mental health services within the scope of the definition provided in section 4 of the *Mental Health Act 2014.* For public mental health services, such as CAHS CAMHS and WACHS CAMHS, the Chief Psychiatrist's Standards apply in addition to the Department of Health's CRAM policy, *Clinical Care of People Who May Be Suicidal Policy*, *Principles and Best Practice for the Clinical Care of People Who May Be Suicidal* and broader *Mental Health Policy Framework*.

Relevantly, the Chief Psychiatrist's *Standard: Risk Assessment and Management* outlines a number of key principles for good risk assessment and management, including a 'no-blame culture' that learns from adverse events and other critical incidents, and that assessments are 'focused on an individual's history and current circumstances' and undertaken across the care continuum:

> **Context**
>
> Mental health services are never risk-free and clinical risks like suicide and violence cannot be predicted with 100% accuracy. Instead, good clinical risk management is based on effective treatment that is focused on an individual's history and current circumstances.
>
> 1. Risk may include:
>   1.1. Risk to self: includes self-harm, suicide and attempted suicide, repetitive self-injury; self-neglect; missing and people absent without leave; physical deterioration including drug and alcohol misuse and medical conditions (including medical conditions secondary to eating disorders); and quality of life including dignity, reputation, social and financial status.

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[554] Department of Health, *Principles and Best Practice for the Clinical Care of People Who May Be Suicidal*, Government of Western Australia, Perth, 2017, viewed 9 September 2018, <http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Mental%20health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf>, pp. 6-8.

[555] Chief Psychiatrist of Western Australia, *The Chief Psychiatrist's Clinical Monitoring Program: Terms of* Reference, Chief Psychiatrist of Western Australia, February 2018, viewed 13 September 2018, <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2018/02/Clinical-Monitoring-Program-ToR-2018.pdf>, p. 3.

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1.2. Risk to others: includes harassment; stalking or predatory intent; violence and aggression; property damage; and public nuisance and reckless behaviour that endangers others.

1.3. Risk from others, especially considering vulnerable persons: includes physical, sexual or emotional harm or abuse by others and social or financial abuse or neglect by others.

2. Risk assessment and management must be legally, ethically and evidence-based.

3. The practice of risk assessment and management is to be person-centred and acknowledge the balance of risk, choice and dignity.

4. Risk assessment and management is a shared, systemic responsibility, underpinned by a 'no-blame' culture.

5. Sentinel incidents and adverse events are reviewed and considered as opportunities for improvement.

6. Risk assessment and management is regarded as a core competency for all mental health clinicians.

7. The principles of risk assessment should underpin the practice of all services providing mental health care.

8. The mental health service should conduct risk assessments of all patients throughout all stages of the care continuum, including patients who are being formally discharged from the service, exiting the service temporarily and/or are being transferred to another service.

9. Risk management during transportation must be compliant with relevant Commonwealth and state transport policies and guidelines, including the current National Safe Transport Principles.[556]

Mental health services are also expected to comply with a number of key criteria when undertaking a risk assessment, including a 'trauma informed and 'holistic' approach that considers information from a broad range of sources and the patient's 'cultural, diverse and individual needs … [and] views':

1. Staff undertaking risk assessments will seek, consider and respond appropriately to information from:
1.1. The patient.
1.2. Carers, families and personal support persons.
1.3. Other records including referring letters and PSOLIS where applicable.
1.4. Other professional assessments.
1.5. Any other person or body considered relevant.

2. Staff will use standardised or equivalent contemporary risk assessment tools and guides, that are appropriate to age and context, which support clinical judgement and clinical decision making and inform a shared management plan.

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[556] Chief Psychiatrist of Western Australia, *Chief Psychiatrist's Standards for Clinical Care: As required under Section 547 of the Mental Health Act 2014*, Chief Psychiatrist of Western Australia, November 2015, viewed 13 September 2018, <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Standards_2015.pdf>, pp. 17-18.

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Noting that actuarial risk assessment tools are of limited predictive value on their own.

3. Staff will use trauma informed care principles.

4. Staff will undertake a holistic risk assessment with consideration of the cultural, diverse and individual needs of the consumer, carer and family as part of the assessment.

5. Staff will always take into account the consumer's views and needs regarding risk including when:
   5.1. They lack capacity.
   5.2. They are under 18 years of age.
   5.3. In the context of an Advance Health Directive.

6. Staff are to include physical health as equal priority in the assessment as outlined in the Standard for Physical Health Care.

7. Risk assessments and reviews of shared management plans will occur regularly and whenever a significant change in the consumer's circumstances is identified which might impact upon risk.

8. Outcomes and changes in risk assessment and management are required to be communicated in a timely way to affected persons and agencies.

9. Following an adverse event, sentinel or critical incident involving serious assault or abuse, injury or death, the restoration and maximisation of the well-being and mental health of all involved is a priority.[557]

In 2016, the Chief Psychiatrist announced his intention to 'conduct a Clinical Standards and Service review at all mental health services within WA over a two year period',[558] including the child and adolescent mental health services delivered by CAHS and WACHS. The objective of this review was:

… to evaluate the standards and consistency of mental health services' clinical governance practices and procedures, with appropriate consideration given to these documents:

- Mental Health Act 2014

- Chief Psychiatrist's Standards for Clinical Care 2015

- National Standards for Mental Health Services 2010

- Mental Health, Alcohol and Other Drug Services Plan 2015-2025

- The Roadmap for National Mental Health Reform 2012-2022 (COAG)

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[557] Chief Psychiatrist of Western Australia, *Chief Psychiatrist's Standards for Clinical Care: As required under Section 547 of the Mental Health Act 2014*, Chief Psychiatrist of Western Australia, November 2015, viewed 13 September 2018, <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Standards_2015.pdf>, pp. 17-18.
[558] Chief Psychiatrist of Western Australia, *The Chief Psychiatrist's Clinical Monitoring Program: Terms of* Reference, Chief Psychiatrist of Western Australia, February 2018, viewed 13 September 2018, <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2018/02/Clinical-Monitoring-Program-ToR-2018.pdf>, p. 6.

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- Carers Recognition Act 2004

- Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia – Professor B Stokes July 2012 ("Stokes Review")

- Historical review processes such as the Chief Psychiatrist's Clinical and Thematic Reviews[559]

All public mental health services were reviewed by the Chief Psychiatrist in the two years between May 2016 and May 2018.

The Chief Psychiatrist reviewed WACHS' mental health services between May to July 2016, and noted in his 2017-18 Annual Report that:

> The review identified five areas of notable practice:
>
> - Mental health assessment
> - Contact details for a variety of supports
> - Physical healthcare – metabolic monitoring
> - Discharge/transfer of care – clarification of accommodation
> - Balancing confidentiality with carer involvement.
>
> Seven recommendations were made, in the areas of drug and alcohol screening, physical examination of inpatients, risk assessment, patient involvement and discharge planning.[560]

CAHS CAMHS was reviewed in May 2017, including all 10 community CAMHS in the metropolitan area, six specialist CAMHS services and the Bentley Adolescent Inpatient Unit.[561] During this investigation, the Chief Psychiatrist informed the Office that his:

> … Clinical Monitoring and Service Review Report for CAHS CAMHS looked at the extent to which risk assessments were undertaken and whether they were consistent with the Chief Psychiatrists Standards for Clinical Care – Risk Assessment Standard. We found that CAHS CAMHS services consistently undertook risk assessments of children accepted by CAMHS, when they were first assessed.

8.2.2.2   CAHS CAMHS Risk Assessment and Management Policy

As discussed in Chapter 2.8 of Volume 2, CAHS CAMHS has developed its own *Risk Assessment and Management Policy*, a local policy setting out 'standardised strategies for recognising and responding to children and young people's risk to themselves and others.'[562] This policy aligns with the broader legislative and policy framework for mental

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[559] Chief Psychiatrist of Western Australia, *The Chief Psychiatrist's Clinical Monitoring Program: Terms of* Reference, Chief Psychiatrist of Western Australia, February 2018, viewed 13 September 2018, <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2018/02/Clinical-Monitoring-Program-ToR-2018.pdf>, p. 4.
[560] Chief Psychiatrist of Western Australia, *Annual Report 2016-17*, Chief Psychiatrist of Western Australia, September 2017, viewed 6 December 2019, <https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypa per/4010721a2fe8c79a2a4a8bdb482581b5002a444c/$file/721.pdf>, p. 43.
[561] Chief Psychiatrist of Western Australia, *Annual Report 2016-17*, Chief Psychiatrist of Western Australia, September 2017, viewed 6 December 2019, <https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypa per/4010721a2fe8c79a2a4a8bdb482581b5002a444c/$file/721.pdf>, p. 44.
[562] Child and Adolescent Health Service – Child and Adolescent Mental Health Service, *Policies: Risk Assessment and Management*, Government of Western Australia, Perth, 2016.

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health service provision in Western Australia, including the Chief Psychiatrist's Standards and the Department of Health's CRAM policy, *Clinical Care of People Who May Be Suicidal Policy*, *Principles and Best Practice for the Clinical Care of People Who May Be Suicidal* and *Mental Health Policy Framework*, as discussed further in Chapter 2.8 of Volume 2.

8.2.2.3 WACHS CAMHS Risk Assessment and Management Policy

WACHS CAMHS does not have its own local risk assessment and management policy, but has instead endorsed the CAHS CAMHS *Risk Assessment and Management Policy* 'as evidence-based recommended practice for use by Medical, Nursing, Midwifery and Allied Health staff … [as] a standard for clinical governance and service delivery.'[563]

8.2.2.4 Since the 2014 Investigation, CAHS CAMHS and WACHS CAMHS have implemented a new service delivery model known as the 'Choice and Partnership Approach' (CAPA)

The implementation of the Choice and Partnership Approach (**CAPA**) is a significant change in the delivery of CAMHS since the 2014 Investigation. With respect to assessment and acceptance or non-acceptance of referrals to CAMHS, CAPA differs from the historical approach:

> Children seen by a traditional CAMHS service are screened, assessed and accepted for treatment or judged to be inappropriate. If accepted, they are often referred within the service for specialist interventions by specialist clinicians.
>
> In the CAPA process newly referred children and their families are invited to attend an initial 'Choice appointment' with the service and are offered a choice of day, time and venue negotiated directly with the family to promote engagement and to provide information about what they can expect.
>
> Children and families attending their 'Choice appointment' are seen by select members of the CAMHS team who have the necessary expertise and skills to ensure that young people and their families are directed to the most appropriate care pathway (within or without the services) from the outset. This 'front loading' of expertise at such an early stage of the care process ensures fast access to effective care and that the need for repeat assessments is reduced.[564]

In England, an evaluation of CAPA found both benefits and challenges arising from implementation of CAPA:

> Potential benefits may include:
>
> • Improved access and reduced waiting times for families entering the service.
>
> • Reduced demands on the service due to improved partnership working with community services and improved flow of families through the service.

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[563] WA Country Health Service, *Child and Adolescent Mental Health Service (CAMHS) Resources – Endorsed for Use in Clinical Practice Policy*, Government of Western Australia, Perth, May 2018, viewed 14 February 2020, <http://wacountry.health.wa.gov.au/fileadmin/sections/policies/Managed/Child_and_Adolescent_Mental_Health_Service_Resources_EUCP_Policy_TS4KSNFPVEZQ_210_13089.pdf>.

[564] Coulter N, *The Choice and Partnership Approach (CAPA) – A model for mental health service transformation*, viewed 6 May 2019, <http://www.qihub.scot.nhs.uk/media/505188/the%20choice%20and%20partnership%20approach%20ann%20york.pdf>.

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- More efficient and more formalized mechanisms of team working.

- Better administrative and management infrastructure to plan services.

- Greater transparency within service, which may lead to improved relationships with service commissioners.

- Less referrals and bottlenecks to specialist clinics.

- Improved clinician skills through joint working.

Potential challenges may include:

- Active planning, monitoring and reviewing for families with complex needs.

- Workers such as child psychotherapists and primary mental health workers may find it difficult to fit their work into the CAPA system due to their own understandings of their role in CAPA.

- Families may wait for long periods of time in between having a Choice appointment and a Partnership appointment if there is not enough capacity within the service or if full booking and job plan review systems are not in place.

- Less experienced staff may lack the confidence and skills required to conduct Choice appointments.

- Capacity planning requires robust service monitoring and a flexible workforce who are willing to extend capacity and roles where necessary.

- CAPA may require managers to be trained in capacity planning in order to implement CAPA. This may be a challenge for teams who do not have a formal capacity plan.[565]

A recent report by the Victorian Chief Psychiatrist also noted the importance of interagency collaboration in effectively implementing CAPA:

> While advocates claim that the CAPA achieves faster and better outcomes than other service delivery models, and better use of specialist resources, its success depends on a timely and responsive mental health service and good partnerships with other agencies in the community. The CAPA also requires strong clinical supervision and systems to help clinicians actively manage their caseloads so that they can continue to take new referrals.[566]

The implementation of CAPA by CAHS CAMHS and WACHS CAMHS is discussed further in Chapter 2.5 of Volume 2.

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[565] National CAMHS Support Service and Mental Health Foundation, *Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England*, Mental Health Foundation, December 2009, viewed 10 September 2018, <https://www.mentalhealth.org.uk/sites/default/files/CAPA_PDF.pdf>, p. 8.
[566] Victorian Government Health and Human Services, *Goulburn Valley Child and Youth Mental Health Service: Chief Psychiatrist's Report,* October 2016, viewed 13 September 2018,
<https://www2.health.vic.gov.au/Api/downloadmedia/%7B00D45B46-E88D-4716-ADB6-A2CA8B045584%7D>, pp. 2-3.

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8.2.3 The Ombudsman's child death reviews identified that 15 children and young people who died by suicide had been referred to CAMHS in the last year of their lives

In the 2014 Investigation, the Office identified that:

- 12 of the 36 young people were recorded as living with one or more diagnosed mental health conditions. All 12 young people were referred to the (then) Child and Adolescent Mental Health Service (**CAMHS**) at some point in their lives. This contact presents an important opportunity to identify and treat mental health conditions and, in doing so, assist in preventing and reducing suicide by young people.

- 8 of the 12 young people were also recorded as having allegedly experienced at least one form of child abuse or neglect. These young people have been included in Group 1. The remaining four young people were recorded as living with one or more diagnosed mental health conditions and as having experienced self-harming behaviour, suicidal ideation and previous suicide attempts. These young people have been included in Group 2.

The Office's examination of 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 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.

As identified in Chapter 7 of this volume, 23 of the 79 children and young people (29 per cent) lived with one or more diagnosed mental health conditions prior to their death, including:

- 16 children and young people who also allegedly experienced child abuse or neglect and are included in Group 1; and

- 7 young people who each demonstrated at least form of suicidal behaviour or ideation and are included in Group 2. None of these young people were alleged to have experienced child abuse or neglect. One young person also had a parent with a diagnosed mental health condition.

The Office considered the CAMHS records obtained during our child death reviews relating to the 79 children and young people who died by suicide during the 2020 Investigation period. During the child death review process, where relevant, the Office obtains files relating to the child's interactions with various State Government departments and authorities during the last 12 to 18 months of their lives.

Records relating to 33 of the 79 children and young people (42 per cent) and their contact with CAMHS were sought during a child death review. Of these 33 children and young people:

- 18 (55 per cent) had no contact with CAMHS in the last year of their lives; and

- 15 (45 per cent) had been referred to CAMHS in the last year of their lives.

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8.2.4 The Ombudsman's child death reviews identified that five young people who died by suicide during the 2020 Investigation were referred to CAMHS in the last year of their lives and their referrals were not accepted, or closed without receiving services. Four of these young people were in Group 2.

From this review of Child Death Review cases, the Office identified five young people who were referred to CAMHS in the last year of their lives and whose referrals were not accepted:

- 1 young person in Group 2 whose referral was closed after their risk was assessed as 'low';

- 3 young people in Group 1 who had their referrals closed and received no CAMHS services due to no contact or moving into a different community CAMHS area; and

- 1 young person in Group 1 who had attempted suicide and declined an urgent appointment with a local CAHS community clinic. This young person was re-referred to CAHS mental health a short time later. This referral was not progressed after CAHS spoke with the young person's caregiver.

8.2.5 The Ombudsman's child death reviews identified that, during the 2020 Investigation, five young people died by suicide while receiving services from CAMHS and four young people died by suicide within one month of discharged from CAMHS

The Office's review of child death review cases also identified that during the 2020 Investigation period, nine young people (of the 15 children and young people referred to CAMHS in the last year of their lives among the 79 children and young people for whom records had been obtained during a child death review) died by suicide while receiving CAMHS services, or shortly after being discharged from CAMHS, in particular:

- 5 children and young people who were receiving services from CAMHS at the time of their death. Four of these children and young people were in Group 1, and one young person was in Group 2; and

- 4 young people who were discharged from CAMHS or the North Metropolitan Area Mental Health Service's YouthLink service within one month of their death. Three of these young people were in Group 1 and one young person was in Group 2.

8.2.6 The Ombudsman's child death reviews have identified that, during the 2020 Investigation, four young people referred to CAMHS died within one year of that referral and did not receive any CAMHS services

Child death reviews conducted by the Ombudsman also identified that, of the 15 children and young people who died by suicide after being referred to CAMHS in the last year of their lives, four young people died without receiving any services as a result of that referral, including:

- 3 young people in Group 1 whose referrals were closed due to 'no contact' or moving into a different community CAMHS area; and

- 1 young person in Group 1 who was referred to CAMHS for 'urgent assessment and management' three weeks prior to their death but was waitlisted.

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8.2.7 Child death reviews conducted by the Ombudsman indicate that professionals or organisations referring children and young people to CAMHS are not being notified of that referral's non-acceptance or closure in 71 per cent of cases

During the 2020 Investigation period, the Office undertook seven child death reviews in which the issue of notifying referrers was considered. From these seven child death reviews the Office identified that:

- on two occasions, the referrer was notified of non-acceptance/closure in accordance with the CAMHS entry protocols;

- on two occasions, the referrer was not notified of non-acceptance/closure/discharge in accordance with the CAMHS entry protocols;

- on one occasion, a professional other than the initial referrer was notified of closure;

- on one occasion, there was a delay of approximately three weeks in notifying the referrer of discharge from CAMHS. The young person in question died three days after this correspondence was sent; and

- on one occasion, communication to the referrer notifying them of closure was sent to an incorrect address.

8.2.8 Aboriginal and Torres Strait Islander children and young people

In the 2014 Investigation, the Office identified that 12 of the 36 young people were recorded as having one or more diagnosed mental health conditions. Eight of the young people were included in Group 1 (these young people were all recorded as having allegedly experienced child abuse or neglect) and four young people were included in Group 2 (none of these young people were recorded as having allegedly experienced child abuse or neglect).

As noted in Chapter 2 of this volume, 23 of the 79 children and young people who died by suicide during the 2020 Investigation period had been diagnosed with one or more mental health conditions. Sixteen of the 23 children and young people diagnosed with a mental health condition were included in Group 1. The other seven young people were included in Group 2.

Among the 35 children and young people recorded as having one or more diagnosed mental health conditions, seven were Aboriginal (20 per cent) and all were in Group 1. By way of comparison, among the 28 non-Aboriginal children and young people recorded as having one or more diagnosed mental health conditions, 17 were in Group 1 (61 per cent) and 11 were in Group 2 (39 per cent).

The Office obtained records from the Department of Health during child death reviews conducted in relation to three of the four Aboriginal children and young people with a diagnosed mental health condition. During these child death reviews the Office identified that two Aboriginal children and young people were open to CAMHS at the time of their death.

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8.3 Patterns and trends in contact between the children and young people who died by suicide and the Department of Communities' child protection services

8.3.1 The 2014 Investigation

In the 2014 Investigation, the Office identified that the patterns and trends in the child protection histories of the 36 young people who died by suicide may have implications for the (then) Department for Child Protection and Family Support. In particular, the Office noted that:

- 20 of the 36 young people were recorded as having allegedly experienced one or more forms of child abuse or neglect, and all of these young people had contact with the (then) Department for Child Protection and Family Support;

- 17 of the 20 young people were recorded as having allegedly experienced more than one form of child abuse or neglect, and are therefore likely to have suffered cumulative harm;

- by assessing the potential for cumulative harm more effectively, the (then) Department for Child Protection and Family Support can assist in preventing or reducing suicide by young people; and

- of the young people in Group 1, Aboriginal young people had higher levels of contact with the (then) Department for Child Protection and Family Support than non-Aboriginal young people.

8.3.2 Children and young people who experience cumulative harm and complex trauma arising from child abuse or neglect are at higher risk of suicide and other mental health issues

In their report *Preventing Suicide: A global imperative*, the World Health Organization identifies that cumulative harm experienced by children and young people can increase the risk of mental-ill health and suicidal behaviours:

> Trauma or abuse increases emotional stresses and may trigger depression and suicidal behaviours in people who are already vulnerable. Psychosocial stressors associated with suicide can arise from different types of trauma (including torture, particularly in asylum-seekers and refugees), disciplinary or legal crises, financial problems, academic or work-related problems, and bullying. In addition, young people who have experienced childhood and family adversity (physical violence, sexual or emotional abuse, neglect, maltreatment, family violence, parental separation or divorce, institutional or welfare care) have a much higher risk of suicide than others. The effects of adverse childhood factors tend to be interrelated and correlated, and act cumulatively to increase risks of mental disorder and suicide.[567]

In their report Trauma and young people: moving toward trauma-informed services and systems, Orygen highlight that:

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[567] World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 36.

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It is now well recognised that the experience of trauma can contribute to, or compound, the development of many different forms of mental ill-health, beyond diagnoses of PTSD. In an Australian study, around two in three children and adolescents attending a Child and Adolescent Mental Health Service (CAMHS) were found to have experienced an adverse event within the past 12 months with 20 per cent experiencing three or more of these adversities. Historically, research has shown that an overwhelming majority of public mental health clients (including adolescents in inpatient care) have multiple experiences of trauma. Trauma experiences can increase the risk of onset of mental ill-health, lengthen the duration of the illness, compound the severity and complexity of mental ill-health and impact on responses to treatment. Further, the experience of severe mental ill-health such as psychosis and some associated service responses and treatment interventions can, in and of itself, be traumatising for young people. …

Childhood abuse and neglect have been associated with suicidal ideation and attempts across adolescents in community, clinical, and high risk samples across all demographics, mental health conditions, family and peer factors, with stronger associations found for sexual and emotional abuse compared to physical abuse and neglect.[568]

The research literature also identifies that the role of child protection authorities when assessing cumulative harm is to ascertain the level of safety for the child or young person and consider the physical, emotional, and educational development of the child or young person:

… may be a factor in any protective concern causing trauma to the child (such as neglect, physical abuse, emotional abuse, sexual abuse or witnessing family violence). Also, because cumulative harm can be caused by a pattern of harmful events, it is unlikely that a child will be reported to child protection explicitly due to concerns about 'cumulative harm. This means that … [the] focus of any assessment and intervention must be to answer two questions: 'Is this child safe?' and 'How is this child developing?'[569]

8.3.3 Developments since the 2014 Investigation

8.3.3.1 *Child protection services in Western Australia are now delivered by the Department of Communities*

On 1 July 2017, as part of machinery of government changes, the former Department for Child Protection and Family Support was amalgamated with the former Department of Housing, Housing Authority, Disability Services Commission, the Regional Services Reform Unit, the regional coordination and engagement component of the former Department of Aboriginal Affairs, and the communities functions (seniors, volunteering, youth and

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[568] Bendall S et all, *Trauma and young people. Moving toward trauma-informed services and systems,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2018, viewed 26 October 2019, <https://www.orygen.org.au/Policy/Policy-Reports/Trauma-and-young-people-Moving-toward-trauma-info/Orygen_trauma_and_young_people_policy_report?ext=.>, pp. 18-19.
[569] New South Wales Government Family and Community Services, *Essential Readings Module 4: Neglect Psychological and Emotional Harm*, Family and Community Services, Sydney, 2015, viewed 20 September 2018, <https://www.childabuseroyalcommission.gov.au/sites/default/files/STAT.1050.001.0326.pdf>, p. 25.

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multicultural interests) of the former Department of Local Government and Communities.[570] The new combined department is now known as the Department of Communities.

8.3.3.2   Amendments to the Children and Community Services Act 2004 and relevant policies have been made to recognise that harm to a child or young person's safety and wellbeing can arise from cumulative patterns of harmful events

As detailed in Chapter 2.9 of Volume 2, legislative amendments have been made to the *Children and Community Services Act 2004* to implement Recommendation 9 of the 2014 Investigation. The Department of Communities has also revised some of its policies and procedures to recognise, consider and appropriately respond to cumulative harm that is caused by child abuse or neglect, as detailed in Chapter 2.10 of Volume 2 and summarised in Figure 85.

Figure 85: References to cumulative harm in relevant Department of Communities policies and procedures, as at 20 September 2018

	Explicit reference to cumulative harm	**Implicit reference to cumulative harm**	**No reference to cumulative harm**
Policies	Policy on Neglect (2012) Emotional Abuse - Family and Domestic Violence Policy (2016)	Signs of Safety Child Protection Practice Framework (2011) Standard 11 of Better Care, Better Services (2017) Policy on Assessment and Investigation Processes (2014)	Policy on Child Sexual Abuse (2009) [under review] Chapter 2.2.4: Child Sexual Abuse Related Resource Roadmap: Family Owned Safety Planning
Procedures	Casework Practice Manual Chapter 2.2.8: Neglect Casework Practice Manual Chapter 1.4: Mental Health and Alcohol and Other Drugs	Chapter 2.2.11 Signs of Safety – child protection practice framework Casework Practice Manual Chapter 2.2: Assessment and Investigation Casework Practice Manual Chapter 2.3.1: Assessing emotional abuse Casework Practice Manual Chapter 2.2.9: Physical abuse	

Source: Ombudsman Western Australia

Other policies and procedures relevant to the Department of Communities' intake, assessment and investigation processes have not been revised in relation to cumulative harm, namely:

- the Policy on Neglect (2012); Signs of Safety Child Protection Practice Framework (2011) and the Policy on Child Sexual Abuse (2009) have not be revised since the 2014 Investigation; and

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[570] Department of Communities, Government of Western Australia, *FAQs*, viewed 26 October 2019, <https://www.communities.wa.gov.au/about/faqs/>.

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- the former Casework Practice Manual Chapter 5.1: Safety and Wellbeing Assessment and Chapter 4.1: Duty Interactions and Initial Inquiries have been amalgamated into the new Chapter 1.4: Assessment and Investigation, however the references to cumulative harm identified in the 2014 Investigation have not been revised.

8.3.3.3 *The research literature has reviewed the introduction and impact of legislative provisions relating to cumulative harm in other Australian states*

Since the 2014 Investigation, the research literature has observed that practice implementation of the Queensland and Victorian legislative references to cumulative harm has not yet had the intended impact on their work with children and families, as:

> … ultimately, the grounds for statutory intervention did not change. Child protection practitioners still need to prove cases of cumulative harm on grounds of emotional abuse and/or neglect. Introducing the term 'cumulative harm' did not address the problem of how the complex notions of emotional abuse and neglect are to fit into a concrete legal argument about cause and effect.[571]

The research literature highlights that the 'lack of legislative requirements that exist to evaluate quantity of re-reporting and re-notifications for a child or the cumulative impact of chronic and pervasive maltreatment'[572] leads to short-term decision-making and an emphasis on episodic assessment and intervention. It is also suggested that this continuing focus on parental (or other caregiver) actions to be linked causally to the detrimental developmental, health or wellbeing effects experienced by a child:

> … perpetuates the idea that maltreatment is episodic, rather than cumulative and denies the intense likelihood that the impact of exposure to chronic maltreatment may not be visible at the time of the exposure, rather it will present over time.[573]

However, recent statistics published by the Australian Institute of Health and Welfare in their report *Child Protection Australia 2017-18* and by the University of South Australia have highlighted that the prevalence of repeated instances of abuse and trauma is much greater than previously estimated, with:

- 1 in 35 children and young people in Australia receiving child protection services in 2017-18,[574] 72 per cent of whom had previously been the subject of a child protective investigation or discharged from a protection order or out of home care placement;[575] and

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571 Broadley K, 'Equipping child protection practitioners to intervene to protect children from cumulative harm: Legislation and policy in Victoria, Australia', *Australian Journal of Social Issues*, vol. 49, no. 3, pp. 265-284, 267.
572 Bryce I, 'Cumulative Harm: A Comparison of International Child Protection Policy and Practice', *Children Australia*, vol. 43, no. 1, January 2018, pp. 23-31, 31, citing O'Halloran K, *Select Committee on Child Protection: Final Report*, 2011, Tasmania.
573 Bryce I, 'Cumulative Harm: A Comparison of International Child Protection Policy and Practice', *Children Australia*, vol. 43, no. 1, January 2018, pp. 23-31, 31.
574 Defined as those children who, after being the subject of a notification to a child protection authority, were the subject of an investigation, a protection order or an out of home care placement.
575 Australian Institute of Health and Welfare, *Child Protection Australia 2017-18*, Australian Government, 8 March 2019.

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- 1 in four children under the age of 10 reported to South Australian child protection authorities, 90 per cent of whom were the subject of multiple alleged instances of abuse and neglect.[576]

This research highlights the systemic issues child protection authorities are facing across Australia in dealing with a much greater volume of vulnerable children, young people and families than the statutory system was originally created for. For example, the Northern Territory previously had a procedural requirement mandating that an assessment must occur if three child protection reports are received within a twelve-month period and are not investigated (**the third report rule**) in the NTFC Procedures Manual. The third report rule was considered during the *Growing them strong, together* inquiry in 2010, which noted that this alternative approach to addressing cumulative harm encountered similar systemic constraints as the implementation of legislative amendments in Victoria and Queensland, instead creating a 'chronic backlog of matters awaiting investigation.'[577]

The *Growing them strong, together* inquiry further noted that:

> Most risk assessment instruments and decision-making processes in child protection services focus on particular harmful events and on the urgency requirements in terms of response. That is, the emphasis is on issues of *urgency* and *imminence* not *significance* of harm. These response elements are necessary ones but in overloaded systems they may become the only areas of focus and thus children who are being seriously harmed but whose circumstances do not require an immediate response, do not get the protection and support they deserve. …

> The Inquiry agrees that the fundamental problem does indeed relate to the availability and quality of services to which families can be referred for assistance … but that the problem of identifying cumulative harm also remains an issue for CI [Centralised Intake].

> The intake service is the gateway to those services that do exist and if cumulative harm cases are not being identified then no assistance will be provided, especially in those complex matters that may require a statutory intervention. Moreover, many of the submissions provide[d] examples of cases involving cumulative harm in which the present harm to children is significant and their developmental prospects are undeniably compromised, yet they did not receive an investigation.[578]

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[576] Puddy R, 'Australia facing an "epidemic of abuse and neglect", according to experts', *ABC News,* 16 September 2018, viewed 26 October 2019, <https://www.abc.net.au/news/2018-09-16/australia-facing-an-epidemic-of-child-abuse-and-neglect/10233898>.

[577] Bamblett M, Bath H and Roseby R, Report of the Board of Inquiry into the Child Protection System in the Northern Territory - Growing them strong, together: Promoting the safety and wellbeing of the Northern Territory's children, 2010, Northern Territory Government, Darwin, 2010, viewed 20 September 2018, <https://childprotectioninquiry.nt.gov.au/__data/assets/pdf_file/0018/242460/CHAPTER_7_The_Statutory_Intervention_Process,_Part_1_Intake_and_Investigation_.pdf>, p. 249.

[578] Bamblett M, Bath H and Roseby R, Report of the Board of Inquiry into the Child Protection System in the Northern Territory - Growing them strong, together: Promoting the safety and wellbeing of the Northern Territory's children, 2010, Northern Territory Government, Darwin, 2010, viewed 20 September 2018, <https://childprotectioninquiry.nt.gov.au/__data/assets/pdf_file/0018/242460/CHAPTER_7_The_Statutory_Intervention_Process,_Part_1_Intake_and_Investigation_.pdf>, pp. 258-260.

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Similarly, in 2015, the Queensland Coroner handed down findings relating to the death of a 13 year old girl in care, in which he noted that systemic factors had prevented effective practice implementation of a legislative framework recognising cumulative harm:

> … the consequence of the system's lack of capacity to meet needs of children like P [who have experienced chronic maltreatment and cumulative harm] in a timely way is a response that, of necessity, becomes crisis driven, reactive and extremely costly. It also sees too many young people move from the child safety system to the criminal justice system.[579]

More recently, the Victorian Commission for Children and Young People examined a sample of 26 children who died by suicide between 1 April 2007 and 22 December 2015, which revealed 'children's devastating and sustained exposure to neglect and abuse without meaningful intervention' and highlighted:

- 'the significant role of cumulative harm in the deaths by suicide of children and young people known to Child Protection';

- that gaps between statutory child protection services and voluntary family support services 'are failing children'; and

- 'inadequate information-sharing between Child Protection and other services … [including] the lack of a shared understanding between services about risk to children and young people'.[580]

Some research literature argues that the key to effective implementation of legislative and policy reform relating to cumulative harm requires a move towards an increasingly therapeutic, child-focused and wellbeing orientated approach, as recognised in the *National Framework for Protecting Australia's Children 2009—2020* that:

> Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children. Leading researchers and practitioners – both in Australia and overseas – have suggested that applying a public health model to care and protection will deliver better outcomes for our children and young people and their families. …

> Under a public health model, priority is placed on having universal supports available for all families (for example, health and education). More intensive (secondary) prevention interventions are provided to those families that need additional assistance with a focus on early intervention. Tertiary (or statutory) child protection services are a last resort, and the least desirable option for families and governments.[581]

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[579] Queensland Courts, Office of the State Coroner, *Findings of Inquest: Inquest into the death of a 13 year old girl (P)*, Coroner's Court, Brisbane, 9 October 2015, viewed 20 September 2018, <https://www.courts.qld.gov.au/__data/assets/pdf_file/0020/441344/cif-p-20151009.pdf>, p. 27.

[580] Commission for Children and Young People, *Annual Report 2017-18,* viewed 20 September 2018, <https://ccyp.vic.gov.au/assets/corporate-documents/CCYP-AR-2018-P6-FINAL-web.pdf>.

[581] Council of Australian Governments, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020*, Commonwealth of Australia, Canberra, 2009, viewed 26 October 2019, <https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf>, p. 7.

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8.3.4 Thirty-nine (78 per cent) of the children and young people in Group 1 of the 2020 Investigation allegedly experienced more than one form of child abuse or neglect, and are therefore likely to have suffered cumulative harm

In the 2014 Investigation, the Office found that 17 of the 20 young people in Group 1 (85 per cent) were recorded as having allegedly experienced more than one form of child abuse or neglect, and are therefore likely to have suffered cumulative harm. The pattern of child abuse or neglect among these 20 young people was as follows:

- 3 young people were recorded as having allegedly experienced one form of child abuse or neglect;

- 10 young people were recorded as having allegedly experienced two forms of child abuse or neglect;

- 5 young people were recorded as having allegedly experienced three forms of child abuse or neglect; and

- 2 young people were recorded as having allegedly experienced all four forms of child abuse or neglect.

As identified in Chapter 7 of this volume, a further 50 children and young people known to the Department of Communities have died by suicide during the 2020 Investigation period.

Of the 50 additional children and young people in Group 1, records indicate that 39 (78 per cent) allegedly experienced more than one form of child abuse or neglect, and therefore are likely to have suffered cumulative harm. The pattern of child abuse or neglect among these 39 children and young people was as follows:

- 11 children and young people allegedly experienced one type of child abuse or neglect;

- 8 children and young people allegedly experienced two types of child abuse or neglect;

- 10 children and young people allegedly experienced three types of child abuse or neglect;

- 16 children and young people allegedly experienced four types of child abuse or neglect;

- 5 children and young people allegedly experienced all five types of child abuse or neglect.

The different forms of child abuse or neglect allegedly experienced by the 50 children and young people in Group 1 are set out in Figure 86. In addition, of the 39 children and young people who allegedly experienced more than one form of child abuse or neglect, records indicated that:

- 27 children and young people demonstrated suicidal ideation, with 19 previously attempting suicide;

- 24 children and young people consumed alcohol at some time in their life, and 22 had consumed cannabis or other illicit drugs;

- 17 children and young people had been diagnosed with a mental health condition;

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- 18 children and young people demonstrated self-harming behaviour; and

- 15 children and young people had a parent with one or more diagnosed mental health conditions, 27 children and young people had a parent with alleged problematic alcohol or other drug use, 12 children and young people had a parent who had been imprisoned, and six children and young people had a family member, friend or other person known to them who had died by suicide.

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**Figure 86: Child abuse or neglect allegedly experienced by the
50 children and young people in Group 1 of the 2020 Investigation**

Young Person ID	Sexual	Physical	Neglect	Exposure to FDV	Other Emotional or Psychological
37			■		
38			■	■	■
39	■				
40	■	■	■	■	■
41	■	■	■		■
42		■		■	
43		■	■	■	■
44	■		■	■	■
45	■			■	■
46	■	■			
47				■	
48		■	■	■	■
49		■	■	■	■
50		■	■		
51	■	■	■	■	■
52	■	■	■	■	■
53	■		■	■	■
54		■	■	■	■
55	■	■	■	■	
56		■	■	■	■
57	■		■	■	■
58	■	■		■	
59		■	■	■	■
60	■		■	■	■
61		■	■	■	■
62		■	■	■	■
63	■		■	■	
64		■	■	■	■
65		■	■	■	■
66	■	■	■		■
67	■	■	■	■	■
68			■	■	
69			■	■	
70	■	■	■	■	
71		■	■	■	
72	■			■	
73	■		■	■	
74	■				■
75	■				
76			■		
77			■		
78	■	■	■	■	■
79	■		■		
80			■		■
81	■	■	■	■	■
82		■	■	■	
83		■	■	■	
84	■				
85		■	■	■	■
86		■	■		■
TOTAL	**22**	**24**	**37**	**36**	**27**

Source: Ombudsman Western Australia

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8.3.5 The Department of Communities received information that raised concerns about the wellbeing of 47 of the 50 children and young people in Group 1 of the 2020 Investigation through 658 interactions

As identified in the 2014 Investigation, there are three key elements to the Department of Communities assessment and investigation processes:

- interactions;

- initial inquiries; and

- safety and wellbeing assessments.

In the 2014 Investigation, the Office identified that the (then) Department of Child Protection and Family Support received information that raised concerns about 17 of the 20 young people in Group 1 who were recorded as having allegedly experienced more than one form of child abuse or neglect through 257 interactions.

The Office conducted additional fieldwork as part of the 2020 investigation, through which the Office has identified that the Department of Communities received information raising concerns about the wellbeing of 47 of the 50 children and young people in Group 1 of the 2020 investigation through 658 interactions shown in Figure 87.[582]

On average, these 47 children and young people came to the attention of the Department of Communities 14 times, with the number of instances where concerns were raised for each individual child or young person ranging from one to 70 occasions.

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[582] This includes 20 requests for financial assistance or financial support.

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**Figure 87: Department of Communities contact with the 47 children and
young people in Group 1 known to the Department of Communities**

Young Person ID	Interactions	Initial Inquiries	Safety and Wellbeing Assessments	Substantiations of harm	Periods in Care of the CEO during lifetime
37	2	0	0	0	0
38	4	0	0	0	0
39	2	1	0	0	0
40	45	6	4	0	0
41	5	1	2	0	0
42	16	2	2	1	1
43	23	2	1	0	0
44	31	5	3	1	0
45	2	0	1	2	0
46	1	1	0	0	0
49	6	0	0	0	0
50	4	2	2	0	0
51	22	5	5	2	1
52	3	0	0	0	0
53	15	5	5	3	0
54	3	0	0	0	0
55	8	2	0	0	0
56	7	1	1	0	0
57	70	3	2	1	0
58	4	0	0	0	0
59	36	5	6	0	1
61	14	2	2	1	0
62	27	4	2	2	1
63	12	6	3	0	0
64	1	0	0	0	0
65	11	1	1	0	0
66	9	3	2	0	0
67	67	11	12	6	2
68	21	3	0	0	0
69	10	3	1	0	0
70	19	0	0	0	0
71	2	1	0	0	0
72	3	0	2	0	0
73	3	1	1	0	0
74	13	5	3	2	5
75	1	1	1	1	0
76	5	1	0	0	0
77	2	1	0	0	0
78	23	8	6	5	4
79	1	1	1	0	0
80	5	2	2	0	0
81	60	7	5	0	1
82	4	0	0	0	0
83	6	1	0	0	0
84	17	1	1	1	0
85	10	1	0	0	0
86	3	0	0	0	0
TOTAL	658	105	76	28	16

Source: Ombudsman Western Australia

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8.3.6 The Office identified 103 interactions in which the Department of Communities recorded the receipt of information alleging abuse, harm or neglect of a child or young person as 'family support', 'practical problem' or 'other crisis issue', rather than a 'child protection' concern

Interactions are recorded using a procedure in the Department of Communities' ASSIST case management system, which requires child protection workers to select a 'primary issue' when entering relevant details about the child or young person, their family, and the person or organisation reporting concerns to the Department.

In her 2007 review of the (then) Department of Community Development, Prudence Ford observed that historically, differences in the proportion of interactions recorded as 'family support' or 'child protection' have fluctuated 'during periods of change in the Department when a family support response was reinforced at a policy level.'[583] Accordingly, the accurate classification of information received by the Department of Communities relating to the wellbeing of a child or young person is essential in order to facilitate timely and easy access to information regarding the child protection history and accurate assessments of whether or not a child or young person has experienced cumulative harm.

Of the 658 interactions relating to the 47 children and young people in Group 1 known to the Department of Communities (of the 79 children and young people), the 'primary issue' was recorded as:

- 'Child Protection' on 229 occasions;

- 'Domestic Violence' on 134 occasions;

- 'Family Support' on 118 occasions, however on 86 occasions the information recorded in these interactions alleged abuse or harm to a child (the majority (82) of these interactions involved allegations of emotional and psychological abuse, or neglect);

- 'Financial Support' or 'Financial Assistance' on 20 occasions;

- 'Practical Problem' on 28 occasions, however on six occasions these interactions contained concerns of neglect, including non-attendance at school, failing to attend for required medical treatment to manage a chronic health issue, and concerns that a child or young person did not have an appropriate caregiver;

- 'Other crisis issue' on 15 occasions, however on 11 occasions the information recorded alleged neglect, emotional harm and sexual abuse, including two occasions where suicide attempts made by a 12 and a 16 year old were noted and no further action was taken by the Department;

- 'Homelessness' on five occasions, all of which included concerns for children aged from nine to 13 years at the time of these contacts and no further action was taken;

- 'Comm Resource Info' on three occasions; and

- 'Request for Information' on one occasion.

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[583] Ford P, *Review of the Department for Community Development: Review Report*, Government of Western Australia, Perth, January 2007, p. 34.

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There were also an additional 104 interactions were the primary issue was recorded as 'Migrated Data' arising from the Department of Communities shift to a new case management system in March 2010, that the Office was unable to assess.

The high proportion of 'family support' interactions which the Office identified as containing information relating to signs of neglect or emotional abuse as defined in the Department of Communities' policy publications (86 of the total 118 'family support' interactions, 73 per cent) indicates that a cumulative harm approach is not yet fully integrated into the Department's duty interaction practice.

The interaction data relating to the 47 children and young people in Group 1 known to the Department of Communities (of the 79 children and young people) only contains eight interactions since the Department's implementation of the new Centralised Intake Model outlined in Chapter 2.11 of Volume 2. Accordingly, it remains to be seen if the new Centralised Intake Model will enable a more consistent identification of cumulative harm.

8.3.7 Of the 658 interactions relating to the 47 children and young people in Group 1 of the 2020 Investigation, the Department of Communities made additional (initial) inquiries for 105 of these interactions, and conducted a safety and wellbeing assessment for 76 of these interactions

The Department of Communities progressed concerns regarding these 47 children and young people to:

- an initial inquiry on 105 occasions, relating to 35 (74 per cent) of the 47 children and young people in Group 1 known to the Department (of the 79 children and young people);

- a safety and wellbeing assessment on 76 occasions, relating to 26 (55 per cent) of the 47 children and young people in Group 1 known to the Department (of the 79 children and young people);

- substantiation of harm on 28 occasions, relating to 13 (28 per cent) of the 47 children and young people in Group 1 known to the Department (of the 79 children and young people); and

- bringing the child into care of the CEO of the Department on 16 occasions, relating to eight (17 per cent) of the 47 children and young people in Group 1 known to the Department (of the 79 children and young people).

For the majority of these 658 interactions (492 interactions, or 75 per cent) the Department of Communities either took 'no further action' or did not progress past the an 'initial inquiry'. Initial inquiries are an introductory phase of child protection involvement:

> … 'undertaken in order to clarify information … to assess whether the Department [of Communities] has a further role in safeguarding or promoting the wellbeing of a child … [and] limited to:
>
> - contact with the referrer
> - contact with the parents, and
> - reviewing Department information.

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… you can request information from outside these sources from, for example, teachers, other family members, WA Police and Department of Health.[584]

8.3.8 The 47 children and young people who were known to the Department of Communities and died by suicide during the 2020 investigation period were the subject of a greater number of interactions, initial inquires and safety and wellbeing assessments between the ages of 12 to 14

The Office considered the ages at which concerns for the 47 children and young people were reported to, and considered by, the Department of Communities as shown in Figure 88:

Figure 88: Department of Communities contact, assessment and investigation for the 47 children and young people (of the 79 children and young people) known to the Department, by age at time of contact
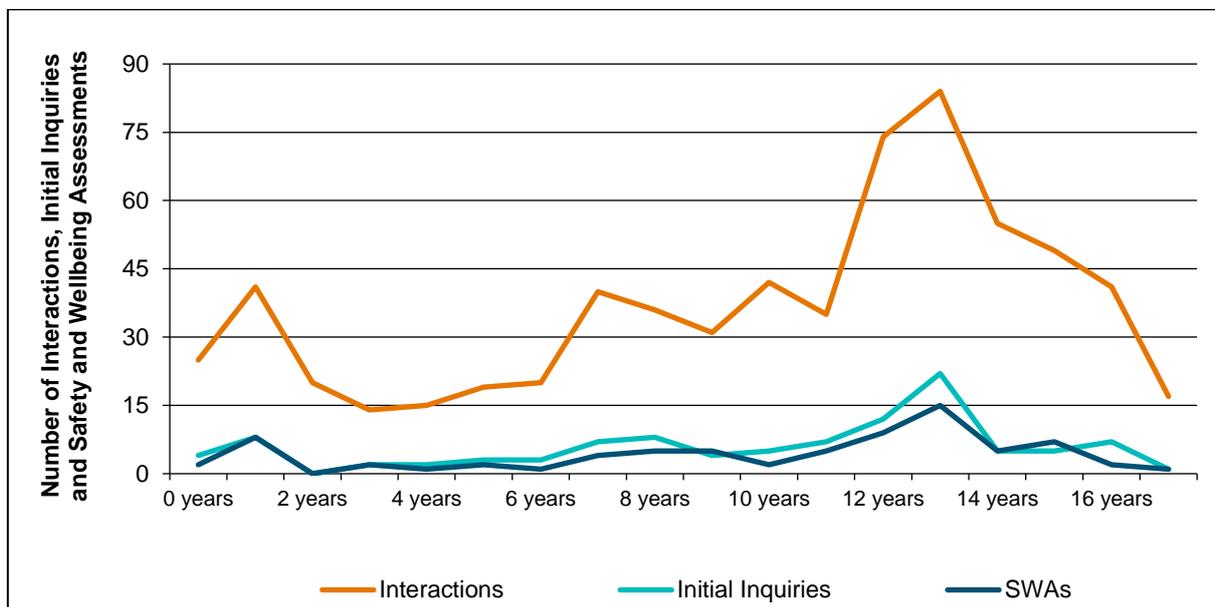
Source: Ombudsman Western Australia

8.3.9 The Department of Communities did not conduct further inquiries or safety and wellbeing assessments for any of the 15 children and young people who were the subject of an additional 96 interactions after a safety and wellbeing assessment was completed

The Office found that, of the 26 children and young people for whom the Department of Communities conducted a safety and wellbeing assessment, further concerns were raised about the wellbeing of that child or young person following the completion of that assessment for 15 children and young people. A total of 96 interactions occurred after the completion of a safety and wellbeing assessment for these 15 children and young people. No further action was taken by Communities in response to these additional concerns on 66 occasions (69 per cent). However, similar to the Office's findings in the 2014 Investigation, none of these 15 children and young people were the subject of a further Safety and Wellbeing Assessment.

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[584] Department of Communities, *Casework Practice Manual 2.2.3 Initial Inquiry*, viewed 6 January 2020, <https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=291>.

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The Office notes the recent steps proposed by the Department of Communities to improve safety and wellbeing assessments undertaken by child protection officers as detailed in Chapter 2.12 of Volume 2.

8.3.10 The Department of Communities' response to information received concerning suicidal behaviours and self-harm of children, young people and their families

The Department of Communities' *Casework Practice Manual* states that:

> If contacted about a child or young person's suicidal thoughts or behaviours, child protection workers should:
>
> - gather information about the extent of the concerns about the child or young person
>
> - review any chronology of past incidents of harmful events or experiences, reports of abuse or neglect
>
> - where possible meet with the child or young person to discuss the concerns about them, (other professionals known to the child or young person may also attend where appropriate)
>
> - contact other individuals to gather information about the extent of the child or young person's suicide concerns
>
> - if the child or young person resides in another district, organise for the appropriate district office to respond, and
>
> - ask the contacting individual if they require any follow-up support, and refer them to an appropriate service.[585]

The Office analysed the Department of Communities records for the 115 children and young people who died by suicide in order to assess whether there had been any changes to the Department's recording of, or responses to, interactions in which a notifier raised concerns that a child or young person was at risk of harm as a result of their own suicidal behaviour or self-harming and/or the suicidal behaviour of a sibling, parent or caregiver.

The Office found that 41 of the 658 interactions relating to the 47 children and young people in Group 1 (of the 79 children and young people who died by suicide in the 2020 investigation period who were known to the Department of Communities) related to concerns about suicidal and self-harming behaviours. Fifteen of these interactions occurred after the 2014 Investigation was finalised and tabled in Parliament, as summarised in Figure 89:

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[585] Department of Communities, Government of Western Australia, *Casework Practice Manual: 1.4.5 Suicide and self-harm*, 3 July 2018, viewed 5 May 2019, <https://manuals.dcp.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=146>.

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Figure 89: Interactions for the for the 47 children and young people in Group 1 known to the Department of Communities that included concerns relating to suicidal or self-harming behaviours

	Interactions that occurred before tabling of the 2014 Investigation	Interactions that occurred after the tabling of the 2014 Investigation	Total
Suicide attempt of child, young person or their sibling/other child relative aged under 18 years			
	9	8	17
Communicated suicidal intention or suicidal ideation of child or young person			
	5	3	8
Self-harming behaviour of child or young person			
	4	2	6
Child or young person who witnessed suicidal behaviour of parent or caregiver			
	4	0	4
Concerns for child or young person's wellbeing after parent or caregiver suicidal behaviour or ideation			
	4	2	6
Total	26	15	41

Source: Ombudsman Western Australia

Nine of these interactions included additional concerns that the parents/caregivers of a suicidal child or young person was unable or willing to provide adequate care for the child or young person.

The Office's analysis of Department of Communities' contact with the 47 children and young people in Group 1 of the 2020 Investigation with a child protection history identified that:

- 43 of the 47 the children and young people in Group 1 known to the Department of Communities were the subject of multiple interactions referring concerns about their safety and wellbeing to the Department;

- a high proportion of these interactions did not proceed to initial inquiries or safety and wellbeing assessments, even where there were indicators that a child had experienced multiple forms of abuse or neglect and their emotional and behavioural development had been negatively impacted as a result of cumulative harm; and

- children and young people who were (or had been) in the care of the Chief Executive Officer of the Department of Communities exhibited particularly complex needs and at an increased risk of suicide.

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> **Recommendation 6:** That the Department of Communities provides the Ombudsman with a report within 12 months of the tabling of this investigation, detailing the proposed strategies to address the following issues raised in this report relating to:
> - identifying and appropriately responding to children and young people and families who are the subject of multiple interactions raising concerns about their wellbeing;
> - the Department's response to interactions raising concerns that a child or young person with a child protection history is at risk of harm as a result of self-harm or suicidal behaviours, including suicide attempts of a parent, carer or guardian; and
> - identifying, and responding appropriately to, children and young people who are in care of the CEO of the Department (or who have left care of the CEO) who are exhibiting escalating self-harm and/or risk-taking behaviours;
>
> including the measures by which the progress of these strategies will be monitored and evaluated.

8.3.11 Aboriginal children and young people in Group 1

In the 2014 Investigation, the Office identified that Aboriginal young people were the subject of higher levels of contact and involvement with the (then) Department for Child Protection and Family Support. Specifically:

- of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child abuse or neglect, nine were Aboriginal and eight were non-Aboriginal;

- 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.

As discussed further in Chapter 6 of this volume, Aboriginal children and young people who died by suicide continued to be the subject of higher levels of contact and involvement with the Department of Communities during the 2020 Investigation. The Office's further analysis of the lives of the 79 children and young people identified that:

- of the 47 children and young people in Group 1 of the 2020 Investigation who were known to the Department of Communities, 27 were Aboriginal (57 per cent), none were Torres Strait Islander, and 20 were non-Aboriginal (43 per cent);

- of the 658 interactions recorded by the Department of Communities about the children and young people in Group 1 of the 2020 Investigation, 485 were about the 27 Aboriginal children and young people in this group (74 per cent); and

- 23 of the 27 Aboriginal children and young people in Group 1 were the subject of initial inquiries or a safety and wellbeing assessment conducted by the Department of Communities (85 per cent), compared to 11 of the 20 non-Aboriginal children and young people (55 per cent).

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8.4 Patterns and trends in contact between the children and young people who died by suicide and the Department of Education

8.4.1 The 2014 Investigation

Under sections 6, 23 and 24 of the *School Education Act 1999* compulsory school aged children are required to attend classes held at a school or an approved registered training organisation. In the 2014 Investigation, the Office identified that the Department of Education used a range of tools, including an attendance strategy and target of 90 per cent over a term, attendance improvement plans, attendance panels and responsible parenting orders (since renamed as responsible parenting agreements) to respond to the needs of children and young people with 'irregular or chronic' non-attendance.

In the 2014 Investigation, the Office identified that patterns and trends in the factors associated with suicide and contact with public schools experienced by the 36 young people who died by suicide may have implications for the Department of Education.

In particular, the Office identified that 19 of the 20 young people in Group 1 (95 per cent) were enrolled at school at the time of their death, 14 (74 per cent) were not regularly attending school or a relevant registered training organisation, as follows:

- 7 (37 per cent) effectively did not attend school or the relevant registered training organisation in the last year of their life;

- 7 (37 per cent) attended school less than 60 per cent of time in the last year of their life;

- 2 (10 per cent) attended between 70 and 89 per cent of the time in the last year of their life;

- 2 (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.

The Office noted that 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.

8.4.2 The research literature identifies that educational institutions have an important role to play in preventing and reducing suicide by children and young people

The World Health Organization, in their report *Preventing Suicide: A resource for teachers and other school staff*, notes that:

> Worldwide, suicide is among the top five causes of mortality in the 15- to 19- year age group. In many countries it ranks first or second as a cause of death among both boys and girls in this age group.
>
> Suicide prevention among children and adolescents is therefore a high priority. Given the fact that in many countries and regions most people in this age group

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attend school, this appears to be an excellent place to develop appropriate preventive action.[586]

The RANZCP has highlighted that behavioural problems are often the first symptoms preceding 'a mental, emotional or behavioural disorder by two to four years and that early therapeutic intervention can be highly effective at limiting the severity and/or progression of problems.'[587] For children:

> … formal schooling [is] … more relevant to prevention and early intervention of mental illness, and in detecting and controlling behavioural and emotional problems. However, it is important to still involve and support families in any school-based programs or initiatives. Additionally, parenting programs can continue to offer effective methods of intervention.
>
> School-based initiatives can aim to improve self-esteem and life skills through school-based curricula of pro-social behaviour and by creating a positive and safe school environment. Resilience building and proactive teaching of cognitive techniques, for example enhancing individual coping skills and promoting social competence, are important tools for preventing and reducing mental health problems. Teachers can be trained to increase detection of problems and facilitate interventions or referrals to mental health professionals. However, early identification of individuals will only be successful in reducing the number and severity of mental health problems in the community if backed with easily accessible and high quality professional assistance.[588]

The 2014 Investigation referred to research literature identifying 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.[589] 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.[590] 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.[591]

The 2014 Investigation also noted that educational institutions are particularly important for children and young people from certain groups, including young people who have experienced child abuse or neglect, resulting in cumulative harm, and Aboriginal young people. Children and young people with a history of child abuse or neglect may have difficulties in learning and interacting in socially appropriate ways.[592] Early trauma reduces

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[586] World Health Organization, *Preventing Suicide: A resource for teachers and other school* staff, WHO, Geneva, 2000, viewed 26 October 2019, <https://www.who.int/mental_health/media/en/62.pdf>, p. 6.

[587] The Royal Australian and New Zealand College of Psychiatrists, Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning strategies for Australia and New Zealand, Faculty of Child and Adolescent Psychiatry, RANZCP, Melbourne, 2010, viewed 26 October 2019, <https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx>, p. 4.

[588] The Royal Australian and New Zealand College of Psychiatrists, Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning strategies for Australia and New Zealand, Faculty of Child and Adolescent Psychiatry, RANZCP, Melbourne, 2010, viewed 26 October 2019, <https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx>, p. 11.

[589] Crawford S and Caltabiano N, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education,* vol. 34, no 23, 2009, p. 29.

[590] Crawford S and Caltabiano N, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education,* vol. 34, no 23, 2009, p. 9.

[591] Randell B, Herting J and Eggert L, 'Family Factors Predicting Categories of Suicide Risk', *Journal of Child and Family Studies*, vol. 15, no. 3, 2006, pp. 247-62.

[592] Beauchamp T, *Addressing high rates of school suspension*, UnitingCare, Parramatta, 2012.

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the capacity to regulate strong emotions, often resulting in conflict with students and teachers.[593]

8.4.3 Developments since the 2014 Investigation

8.4.3.1 The Department of Education has amended policies and procedures relevant to identifying and responding to student attendance, student behaviour, and students at risk of self-harm or suicide

As set out in Chapters 2.15 to 2.21 of Volume 2, the Department of Education has made a range of changes to its policies and procedures since the 2014 Investigation, including in relation to student behaviour, student attendance and identifying and responding to children and young people allegedly experiencing abuse or neglect or being at risk of self-harming or suicidal behaviours.

8.4.4 During the last year of their lives, 38 of the 50 children and young people in Group 1 of the 2020 Investigation were enrolled at a public school. 23 of the 38 children and young people enrolled at school (61 per cent) attended less than 60 per cent of the time.

The Office obtained school attendance records from the Department of Education for the 50 children and young people in Group 1 of the 2020 Investigation:

- 49 of the 50 young people in Group 1 attended a public school at some time during their lives; and

- 38 of the 49 children and young people in Group 1 were enrolled at a public school during the last year of their life, and therefore required to be regularly attending school.

For those 38 children and young people enrolled at a public school during the last year of their life, their attendance during that last year ranged from 0 to 98.7 per cent. However, of those 38 children and young people, 23 (61 per cent) were not regularly attending school and were at 'severe educational risk' under the Department of Education's *Managing Student Attendance in Western Australian Public Schools* policy, as follows:

- two (5 per cent) effectively did not attend school or the relevant registered training organisation in the last year of their life;

- twenty-one (57 per cent) attended school less than 60 per cent of time in the last year of their life;

- six (16 per cent) attended between 60 and 69 per cent of the time in the last year of their life;

- seven (18 per cent) attended between 70 and 89 per cent of the time in the last year of their life; and

- two (5 per cent) attended more than 90 per cent of the time in the last year of their life.

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[593] Beauchamp T, *Addressing high rates of school suspension*, UnitingCare, Parramatta, 2012.

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None of the 38 children and young people enrolled at a public school during the last year of their life appeared on the 'Students whose Whereabouts are Unknown List' (known as the 'SWU List') during that year.

8.4.5 Ten of the 49 children and young people in Group 1 who attended a public school during their lives had been suspended for more than 10 days, including 3 children and young people had been suspended for more than 20 days during a school year

In the 2014 Investigation, the Office identified that:

- 10 of the 19 young people in Group 1 enrolled at school at the time of their death had been suspended from school (53 per cent);

- five of the 19 young people enrolled at school had been suspended from school for more than 10 days during a school year (26 per cent), and three young people went on to be suspended for more than 20 days during a school year (16 per cent); and

- 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.

During the 2020 investigation, the Office obtained school suspension data for 49 of the 50 children and young people in Group 1 who had attended a public school at some time during their lives, and identified that:

- 10 of the 49 children and young people (20 per cent) had previously been suspended for more than 10 days in a school year; and

- three of those 10 children and young people (six per cent) went on to be suspended for more than 20 days in a school year.

The Office has also considered information regarding student behaviour obtained during child death reviews. The Office's Reviews team obtained school behaviour management records in relation to four children and young people in Group 1 of the 2020 Investigation who had been suspended from school. During these four reviews, the Office identified that:

- behaviour management actions were taken in a manner consistent with the Department of Education's Student Behaviour Policy for two of these children and young people; and

- in relation to two children and young people, the Department of Education's actions in response to behavioural issues did not comply with the Student Behaviour policy.

8.4.6 Aboriginal children and young people

In the 2014 Investigation, the Office identified that:

- nine of the 10 Aboriginal young people in Group 1 attended school less than 60 per cent of the time (90 per cent);

- 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; and

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- of the 10 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 (40 per cent).

As identified in Chapter 8.4.4 of this volume, the Office obtained school attendance records from the Department of Education for the 50 children and young people in Group 1 of the 2020 Investigation and identified that:

- 49 of the 50 young people in Group 1 attended a public school at some time during their lives;

- 38 of the 49 children and young people in Group 1 were enrolled at a public school during the last year of their life, and therefore required to be regularly attending school; and

- 23 (61 per cent) of those 38 children and young people in Group 1 enrolled at a public school during the last year of their life were not regularly attending school and were at 'severe educational risk' under the Department of Education's *Managing Student Attendance in Western Australian Public Schools* policy

The Office's analysis further identified that, of the 50 children and young people in Group 1:

- 27 were Aboriginal (54 per cent);

- 20 of the 27 Aboriginal children and young people in Group 1 (74 per cent) were enrolled in a public school during the last year of their life.

Of those 20 Aboriginal children and young people in Group 1 enrolled in a public school during the last year of their life:

- 12 (60 per cent) attended school less than 60 per cent of the time in the last year of their life;

- four (20 per cent) attended school between 60 and 70 per cent of the time in the last year of their life;

- four (20 per cent) attended between 80 and 89 per cent of the time in the last year of their life; and

- none had school attendance rates of less than 8 per cent, or above 90 per cent.

In the course of the Ombudsman's child death reviews, the Department of Education has identified a number of gaps in relation to attendance intervention relating to some of these children and young people and undertaken to address these.

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9. Information sharing and inter-agency collaboration

9.1   Introduction

9.1.1 The 2014 Investigation

In the 2014 Investigation, the Office identified the importance of State government departments and authorities:

- sharing information to facilitate the effective identification of young people at risk of suicide; and

- making a collaborative effort to prevent and reduce suicide by young people who experience multiple risk factors associated with suicide and have contact with multiple State government departments.

9.1.2 The research literature identifies that challenging behaviours exhibited by children and young people experiencing cumulative harm are often not understood in the context of trauma

The United Kingdom Office for Standards in Education, Children's Services and Skills (Ofsted) report *Growing up neglected: a multi-agency response to older children* identifies that:

> Older children who suffer neglect may have been neglected for many years and can carry the legacy and impact of neglect at a younger age with them into adolescence. This means they are often not well equipped to cope with the many challenges that older childhood brings and may not get the support from parents to manage this transition. Many children reviewed during these inspections had experienced multiple forms of abuse, both within the home and outside the home. As a result, many were experiencing trauma and, in some cases, post-traumatic stress. …

> Research suggests that physical and visible aspects of neglect are the ones most often identified by professionals. The appearance of home conditions, a failure to address a child's medical needs or delays in physical development are common ways of identifying neglect. These can be easier to identify than other forms of neglect a child may experience, such as emotional neglect.

> Neglect of older children may look very different to that of a young child or baby. Older children may also be skilled at hiding the impact of neglect by seeking support from places other than the family or by spending more time away from home, which in itself may put the child at more risk. They may appear 'resilient' and to be making choices about their lives, when in fact they are adopting behaviours and coping mechanisms that are unsafe. For example, they may look for support from inappropriate and dangerous adults or use alcohol and drugs as a form of escape. …

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What older children require from their parents is also different to what younger children need. Older children face risks outside of the home in ways that younger children do not. Parents may not always be equipped to help their older children deal with increased risks outside the home. Alternatively, because their parents are neglecting them at home, older children may spend more time away from the home, which increases their risk of exposure to child sexual exploitation, criminal exploitation, gang-related activity or violence. These, then, are the problems that professionals first see when they encounter a neglected child and these may well be the issues they respond to.[594]

As noted by the New South Wales CDRT:

The death of a child as a direct result of chronic neglect, … is rare. Neglect related deaths most often result from unintentional or reckless acts on the part of a carer that may occur in a broader environment of neglect. Between 2010 and 2015, 293 children who died and were known to FACS had experienced neglect, or there was a significant history of neglect within their family. Of these children, just under one quarter (68) died in circumstances where neglect was a 'contributing factor'. Similar observations have been made in England; Brandon et al have noted that while neglect is very rarely the primary and immediate cause of child death, 'neglect was evident in the majority (60%) of serious maltreatment and fatality reviews'.[595]

9.1.3 Since the 2014 Investigation, some jurisdictions have introduced targeted multi-agency interventions to help meet the needs of older children and young people who have experienced cumulative harm or are at risk of suicide

9.1.3.1 New Zealand

In New Zealand, the Ministry for Children has implemented a new approach to working with children and young people 'who don't quite cross the threshold to be involved in care and protection services, but still have complex needs' including:

- children living in homes where family violence is present
- children who have difficulty attending school or engaging when present
- children with social or behavioural problems
- children with unaddressed health issues
- whānau [family] struggling with social or economic issues who have dependent children
- whānau with dependent children where parenting capacity needs to be strengthened
- whānau with dependent children for whom a statutory intervention may be required if concerns and risk factors are not addressed.

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[594] Ofsted, Care Quality Commission, HMI Constabulary and Fire & Rescue Services and HMI Probation, *Growing up neglected: a multi-agency response to older children*, July 2018, viewed 26 October 2019, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722740/Older_childr en_neglect_FINAL_060718.pdf> pp. 8-10.

[595] Ombudsman New South Wales, *Child Deaths: Report of Reviewable Deaths 2014 and 2015*, Ombudsman New South Wales, Sydney, June 2017, p. 45.

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The Children's Teams are voluntary and bring together 'health, education, welfare, housing, social services, … cultural and community support'[596] services and are supported by an information management system that:

> … records, stores and provides access to information and concerns about at-risk children and young people, including case management and reports on outcomes.

> Practitioners from different agencies, non-government organisations and service providers with appropriate access all use ViKI [the Vulnerable Kids Information System] as part of their role working with the Children's Team.

> Teams can share what they know about a child, and their family or whānau. It allows them to build a more complete picture of the situation and put together an integrated and coordinated plan of services to meet the child's needs.[597]

9.1.3.2   New South Wales

In New South Wales, 'Whole Family Teams' (**WFTs**) were established to 'include mental health and drug and alcohol clinicians working together in multidisciplinary teams to provide comprehensive mental health, drug and alcohol and family assessment and evidence informed individual and family in-home interventions for approximately six months'.[598]

The WFT model of intensive home based specialist support provides 'tertiary level mental health and drug and alcohol interventions for parents and early intervention for children [of parents experiencing mental health, drug or alcohol issues]'.[599] An independent evaluation of the WFT model found that:

> More than 200 families with complex needs have been provided a specialist health service each year. An economic analysis based on case study evaluation data suggests that WFTs may have potential long-term positive economic impacts that outweigh the program's costs. A formal cost effectiveness analysis, subject to data availability, would be useful and quantify this during the next two year phase.

> The independent *KTS-WFT Final Report* found a statistically significant (58.4%) reduction in the mean rate of Risk of Significant Harm reports for children in families who completed the WFT program.

> Consistent and statistically significant improvements across a range of clients interviewed as part of the WFT evaluation reported they valued the interventions, such as clear communication, a non-judgmental, sensitive and consultative approach and home visiting, that addressed their mental health or drug and

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[596] Oranga Tamariki Ministry for Children, 'Children's Teams', *Working with children*, viewed 26 October 2019, <https://www.orangatamariki.govt.nz/working-with-children/childrens-teams/information-for-families/>.

[597] Oranga Tamariki Ministry for Children, 'Children's Teams', *Working with children*, viewed 26 October 2019, <https://www.orangatamariki.govt.nz/working-with-children/childrens-teams/how-they-work/>.

[598] NSW Government Agency for Clinical Innovation, *Keep Them Safe and Whole Family Teams – An Integrated Partnership Approach to Health Care*, 5 March 2015, viewed 26 October 2019, <https://www.aci.health.nsw.gov.au/ie/projects/keep-them-safe-and-whole-family-teams>.

[599] NSW Government Agency for Clinical Innovation, *Keep Them Safe and Whole Family Teams – An Integrated Partnership Approach to Health Care*, 5 March 2015, viewed 26 October 2019, <https://www.aci.health.nsw.gov.au/ie/projects/keep-them-safe-and-whole-family-teams>.

alcohol problems enabled them to become a better parent and improve their capacity to meet the needs of their children.[600]

9.1.3.3 Queensland

In Queensland, the State government has developed the 'Logan Together' initiative to provide a long-term early intervention for children and young people in Logan:

> It aims to reduce rates of developmental vulnerability for Logan children to the state average by 2025 so that children in Logan can grow up as healthy and full of potential as other Queensland children. Logan Together works with individuals, other community organisations, government departments and agencies, politicians and funding bodies to achieve their goal. Their six priority projects are:
>
> 1. community maternity and child health hubs strategy
>
> 2. the first three years: early development initiatives
>
> 3. early years neighbourhood networks
>
> 4. community mobilisation campaign
>
> 5. jobs for families project
>
> 6. social investment and service integration reforms.[601]

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

In the 2014 Investigation, the Office identified that:

- 19 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 abuse or neglect. Most of these young people were also recorded as having experienced mental health issues 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',[602] and agencies face challenges in providing services to these young people.[603] The profile of 'hard to help' young people described in the research literature was similar to those young people in Group 1.

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[600] NSW Government Agency for Clinical Innovation, *Keep Them Safe and Whole Family Teams – An Integrated Partnership Approach to Health Care*, 5 March 2015, viewed 26 October 2019, <https://www.aci.health.nsw.gov.au/ie/projects/keep-them-safe-and-whole-family-teams>.

[601] Royal Australian and New Zealand College of Psychiatrists*, Submission to the Legal and Social Issues Committee's Inquiry into youth justice centres in Victoria,* 21 September 2018, viewed 26 October 2019, <https://www.ranzcp.org/files/resources/submissions/ranzcp-qld-submission-on-youth-justice-strategy-se.aspx>, pp. 2-3.

[602] Brandon M et al, 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.

[603] Brandon M et al, 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.

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- 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 (then) Department for Child Protection and Family Support and the Department of Education. These departments could be important parties to a case management approach.

The Office also noted that one example of a case management approach for at-risk young people was the Young People with Exceptionally Complex Needs program (**the YPECN program**) which, in 2012, had the capacity to support up to 10 young people for a period of up to two years.

As part of the 2020 investigation, the Office sought additional information from the Department of Communities regarding the current status of the YPECN program. The Department of Communities relevantly informed the Office that:

Aim
The Young People with Exceptionally Complex Needs (YPECN) program aims to provide a coordinated service delivery response to improve the well-being and quality of life of young people with exceptionally complex needs.

Target Group
- Young people who have two or more of the following:
  - A mental illness.
  - An acquired brain injury.
  - An intellectual disability.
  - A significant substance abuse problem and;
- Pose a significant risk of harm to themselves and or others.
- Require intensive support and would benefit from receiving coordinated services and,
- For whom the existing system is not working as it should.

Model
The program consists of:
- an Inter-agency Executive Committee of partner agencies;
- a YPECN Inter-agency Coordinator appointed to ensure inter-agency coordination; and a
- Young Person's Services Team comprised of: family; existing and potential services and supports.

Partner agencies are:
- Department of Communities – Child Protection and Family Support.
- Department of Communities – Disability Services.
- Department of Communities – Housing
- Mental Health Commission.
- Department of Health, Child and Adolescent Mental Health.
- Department of Education.
- Department of Corrective Services, Youth Justice.
- Drug and Alcohol Office.
- Office of the Public Advocate.

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Referral Process

Referrals are called for when a vacancy arises through the partner agency's YPECN contact person. Once a referral is received:

- The Inter-agency Coordinator confirms YPECN criteria are met and that the young person is in scope for the program.
- The Inter-agency Coordinator refers to the Inter-agency Executive Committee to consider the young person for the program.
- Acceptance on to the program is by consensus of the sitting members of the IEC. If the referral is not accepted further information may be sought and the referral reconsidered as a young person for discussion at a later meeting.

YPECN Process

- Inter-agency Coordinator convenes the Young Person's Services Team to identify needs and issues.
- Young Person's Services Team agrees on a plan, indicators of success, agreed actions and responsibilities. A key worker, resources required, meeting frequency and review processes are also identified.
- Inter-agency Coordinator convenes regular meeting with the Young Person's Services Team to implement support plan.
- The support plan is reviewed and changed as required.
- Inter-agency Coordinator updates the Inter-agency Executive Committee on a regular basis to update on progress of the young person; request assistance to address strategic barriers and seek information to support the young person's plan

Current YPECN cohort (as of June 2018)

- There are currently 14 young people in the YPECN program.
- 9 of the 14 young people are in the care of the CEO.
- The youngest two participants are 12 years of age and the eldest is 19 years of age.
- 4 of the 14 young people identify as ATSI.
- All participants have identified drug issues (drugs include methamphetamines; solvent abuse and marijuana.)
- All participants have an identified mental health condition.
- 7 of the 14 participants are registered with Disability Services and /or NDIS.

YPECN Exit Process

As the support network becomes cohesive and the previously identified gaps and barriers have resolved, the Coordinator and the Young Person's Services Team develop a transitional plan so that YPECN can withdraw its service.

The Coordinator advices the Inter-agency Executive Committee of the transition plan and closure letters are submitted for endorsement.

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9.2 Developments since the 2014 Investigation

As identified in Chapter 2.22 of Volume 2, the Mental Health Commission, Department of Health, Department of Communities and Department of Education have formed an Interagency Executive Committee to consider the development of a collaborative inter-agency approach for children and young people with multiple risk factors for suicide, a shared screening tool and a joint case management approach.

During the Education and Health Standing Committee's 2016 Inquiry into Aboriginal Youth Suicide in Remote Areas, the Telethon Kids Institute and the Menzies School of Health Research noted the importance of this work in their joint submission, as follows:

> An important recommendation of the Ombudsman's report relates to an issue that is seen across the board in this area [of youth suicide prevention] and that is the issue of a lack of collaboration and information sharing between agencies. The Ombudsman's recommendation that the MHC, the DCPFS and Department of Education develop a collaborative inter-agency approach for young people will go some of the way of addressing the issue of children and young people falling through the gaps in service delivery. Telethon Kids is unsure as to whether this recommendation has been progressed. A coordinated and integrated information system for children and adolescents at high risk is needed to ensure effective communication between multiple agencies working on the same case. This is seen as a critical component of improving inter-agency collaboration when dealing with family situations where multiple risk factors need to be addressed.[604]

In the Education and Health Standing Committee's subsequent report, *Learnings from the message stick*, it noted that:

> In response to a recommendation [Recommendation 22] in *Ombudsman 2014*, an Interagency Executive Committee has been formed to oversee collection of agency data on children and young people with a combination of risk factors identified in the Ombudsman's report … The MHC is investigating ways to refine the data to identify a priority "at greatest risk" group.
>
> The Committee is disappointed this is the extent of the implementation of the recommendation more than two years after the publication of *Ombudsman 2014*. The Committee understands that the Ombudsman will soon be reporting on the implementation of recommendations arising from own motion investigations. It will be interested to know the Ombudsman's assessment of the implementation of this important recommendation.[605]

Changes to the *Children and Community Services Act 2004* are also relevant, as noted by the (then) Department for Child Protection and Family Support:

- Since 2011, the Children and Community Services Act 2004 (WA) has made it possible for certain government authorities ("prescribed authorities") to share information that is relevant to the wellbeing of a child or children ("relevant information") directly with one another. This has allowed the exchange of relevant information between prescribed authorities in relation

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[604] Telethon Kids Institute and Menzies School of Health Research, *Submission No. 18 to the Education and Health Standing Committee Inquiry into Aboriginal youth suicide in remote areas*, Legislative Assembly, Parliament of Western Australia, Perth, 24 May 2016, p. 5.

[605] Education and Health Standing Committee, *Learnings from the message stick: the report of the inquiry into Aboriginal youth suicide in remote areas*, Legislative Assembly, Parliament of Western Australia, Perth, 2016, p. 163.

to cases or matters in which the Department for Child Protection and Family Support is not necessarily involved.

- From 1 January 2016, using section 28B of the Children and Community Services Act 2004, prescribed authorities will also be able to exchange relevant information with "nongovernment providers" and non-government schools.

- The type of information that can be shared is also being broadened to include information that is relevant to the safety of persons subjected or exposed to family and domestic violence.

Seeking consent before sharing relevant information remains best practice in information sharing provided it does not compromise a person's safety or wellbeing to do so. However, at times it can be necessary to share information without the consent of the person/s the information relates to. The new laws will enable this to occur by providing important protections from legal liability or breach of professional codes of conduct to people who, in good faith, share relevant information.[606]

More recently, the Western Australian Government has announced its commitment to Privacy and Responsible Information Sharing legislation and stated that:

WA also does not have a clear, overarching information-sharing framework, meaning members of the public have to provide the same information to multiple public agencies when updating simple details like change of address, and government departments are not making the best use of their combined knowledge when delivering public services.

The WA Government is proposing to introduce a whole-of-government framework to meet the twin priorities of protecting Western Australians' privacy and enabling information to be safely used for their benefit.[607]

Significantly, the *Privacy and Responsible Information Sharing for the Western Australian Public Sector Discussion Paper*[608] (**the Discussion Paper**) outlines how responsible information sharing within government and with authorised third parties can 'assist with the delivery of 'joined up' government services. The Discussion Paper provided examples of how information sharing can provide a resource to improve child protection services, programs and policies and provide data-driven decision making to improve service provision and policy to reduce suicide and self-harm across Australia.

Recommendation 7: That the Mental Health Commission, Department of Health, Department of Communities and Department of Education work collaboratively to develop and implement an evidence-based inter-agency model for responding to children and young people with complex needs, including those experiencing multiple risk factors associated with suicide.

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[606] Department for Child Protection and Family Support, *New information-sharing laws under the Children and Community Services Act 2004 (WA) – section 28B,* 2015, viewed 6 October 2019, <https://www.dcp.wa.gov.au/Organisation/Documents/Implementation%20information%20for%20the%20non%20government%20sector.pdf>, p. 1.

[607] Western Australian Government, 'State Government's commitment to stronger, clearer privacy protections for Western Australians' (Media Statement), 5 August 2019, viewed 26 October 2019, <https://www.mediastatements.wa.gov.au/Pages/McGowan/2019/08/State-Governments-commitment-to-stronger-clearer-privacy-protections-for-Western-Australians-.aspx>.

[608] Western Australian Government, Privacy and Responsible Information Sharing for the Western Australian Public Sector Discussion Paper, 2019, p. 33.

Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce deaths of children by drowning	**November 2018**
Investigation into ways to prevent or reduce deaths of children by drowning	**November 2017**
A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities	**November 2016**
Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities	**November 2015**
Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people	**April 2014**
Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths	**November 2012**
Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004	**November 2011**
The Management of Personal Information - good practice and opportunities for improvement	**March 2011**
2009-10 Survey of Complaint Handling Practices in the Western Australian State and Local Government Sectors	**June 2010**