Investigation into family and domestic violence and suicide

Volume 1: Executive Summary

Ombudsman Western Australia

About this Report

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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 emerging.

CONTENT WARNING

This report contains information about suicide, family and domestic violence 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 women and children who died by suicide.

The Institution of the Ombudsman

The institution of the Ombudsman is more than 200 years old. The institution of the Ombudsman promotes and protects human rights, good governance and the rule of law as recognised through the adoption in December 2020 by the United Nations General Assembly of Resolution 75/186, *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*.

The International Ombudsman Institute, established in 1978, is the global organisation for the cooperation of 205 independent Ombudsman institutions from more than 100 countries worldwide. The IOI is organised in six regional chapters - Africa, Asia, Australasian and Pacific, Europe, the Caribbean and Latin America and North America.

Ombudsman Western Australia

Ombudsman Western Australia is one of the oldest Ombudsman institutions in the world. The Ombudsman is an independent and impartial officer who reports directly to Parliament. The Ombudsman receives, investigates and resolves complaints about State Government agencies, local governments and universities, undertakes own motion investigations, reviews child deaths, reviews family and domestic violence fatalities and undertakes inspection, monitoring and other functions.

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The Ombudsman Western Australia and Aboriginal Western Australians

Ombudsman Western Australia acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of this land. We recognise and respect the 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 emerging.

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Getting help and finding support

If a life is in danger, or someone you know is at immediate risk of harm, call 000.

If you, or someone you are with is highly distressed, feeling unsafe and thinks they are a risk to themselves, go to your nearest emergency department.

If you are worried about a person who refuses to go to an emergency department, and need urgent mental health assistance, please contact:

Mental Health Emergency Response Line: 1300 55 788 (Perth) or 1800 676 822 (Peel)

rapid response for after-hours mental health emergencies in the Perth and Peel metro areas, or connection to your local mental health service during business hours

Rurallink: 1800 552 003 (regional Western Australia, free call)

specialist after hours mental health telephone service for people in rural communities, 4.30 pm to 8.30 am, Monday to Friday and 24 hours Saturday, Sunday and public holidays, and for connection to your local mental health service during business hours

Suicide Call Back Service: 1300 659 467 or suicidecallbackservice.org.au

free phone, video and online counselling for people at risk of suicide, concerned about someone at risk, bereaved by suicide and people experiencing emotional or mental health issues

Child and Adolescent Mental Health Service Crisis Connect: 1800 048 636

phone and online videocall support for children and young people experiencing a mental health crisis as well as support and advice to families and cares, available seven days a week from 8.30 am to 2.30 pm across the Perth metro area

Australia-wide 24 hour mental health support lines

Lifeline: 13 11 14 or lifeline.org.au

24 hour telephone crisis support and suicide prevention online crisis support chat available from 7 pm to midnight AEST

13 YARN 13 92 76

the first national crisis support line for mob who are feeling overwhelmed or having difficulty coping, they offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal & Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week

Beyond Blue: 1300 22 4636 or beyondblue.org.au

immediate support available 7 days a week, through phone (24 hours), online chat (3 pm to 12 am) or email (response within 24 hours)

1800RESPECT: 1800 737 732 or 1800respect.org.au

24 hour phone and web chat counselling for people impacted by sexual assault, domestic or family violence and abuse

MensLine Australia: 1300 78 99 78 or mensline.org.au

phone, video and web counselling for men who want to take responsibility for their violence and have healthy and respectful relationships

StandBy Support After Suicide: 1300 72 77 47

a program focused on supporting anyone who has been bereaved or impacted by suicide at any stage in their life

Additional support services

Women's Domestic Violence Helpline: 1800 007 339

provides support for women, with or without children, who are experiencing family and domestic violence in Western Australia (including referrals to women's refuges)

Men's Domestic Violence Helpline: 1800 000 599

provides telephone information and referrals for men in Western Australia who are concerned about their violent and abusive behaviours

Crisis Care: 9223 1111 or 1800 199 008

provides Western Australia's after-hours response to reported concerns for a child's safety and wellbeing and information and referrals for people experiencing crisis

Sexual Assault Resource Centre: (08) 6458 1828 or freecall 1800 199 888

provides a range of free services to people affected by sexual violence

Derbarl Yerrigan Health Service: 9241 3888 or dhys.org.au

health and medical support for Aboriginal people, including counselling, Mon-Fri 9 am to 5 pm

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

phone, web chat or email counselling support for people affected by complex mental health issues, available from 10 am to 10 pm AEST

GriefLine: 1300 845 745 (landlines) or (03) 9935 7400 (mobiles) or griefline.org.au

free phone counselling and support for people experiencing grief, loss and trauma, 6 am to midnight AEST, seven days a week

Active Response Bereavement Outreach (ARBOR): 1300 11 44 46 or arbor.bereavement@anglicarewa.org.au

a free service offering short-medium term grief counselling, practical & emotional support, appropriate referral support, volunteer lived-experience peer support, and support groups to people recently impacted by losing loved ones to suicide

QLife: 1800 184 527 or qlife.org.au

3 pm to midnight, 7 days per week, telephone and webchat counselling for LGBTI people

Support services for children and young people

Kids Helpline: 1800 55 1800 or kidshelpline.com.au

24 hour telephone and web chat support for kids, teens and young adults from 5 to 25 years and their parents, carers, teachers, and schools

headspace: headspace.org.au/eheadspace

free telephone and online support and counselling for children and young people 12 to 25 years, their families and friends

Children and Young People Responsive Suicide Support (CYPRESS): 1300 11 44 46 or info@anglicarewa.org.au

support service for children and young people between the ages of 6 and 18 who have been bereaved by suicide

Translating and interpreting

If you are assisting someone who does not speak English, first call the Translating and Interpreting Service (**TIS**) on 13 14 50 and they can connect you with the service of your choice and interpret for you.

If you, or the person you are assisting, has a hearing or speech impairment, contact the National Relay Service online or via their Helpdesk on 1800 555 660 and quote 08 9220 7555 to be connected with the Ombudsman's office.

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Ombudsman's Foreword

As Ombudsman, I undertake the important responsibilities of reviewing family and domestic violence fatalities and child deaths. Arising from this work, I identified the need to undertake a major own motion investigation into family and domestic violence and suicide.

To undertake this investigation, in addition to an extensive literature review and stakeholder engagement, my office collected and analysed a comprehensive set of state-wide data relating to those who died by suicide in circumstances where family and domestic violence had previously been identified by one or more State government departments or authorities. This included an examination of 68 women and child victims of family and domestic violence who died by suicide in 2017.

I have found that a range of work has been undertaken by State government departments and authorities to administer their relevant legislative responsibilities to support the safety of women and children experiencing family and domestic violence. I have found, however, that there is important further work that should be done. This work, detailed in the findings of this report, includes a range of important opportunities for improvement for State government departments and authorities, working individually and collectively, across all stages of the service spectrum to improve the identification of, and responses to, family and domestic violence in Western Australia.

In addition, this investigation has identified the need for State government departments and authorities to use a trauma informed approach when working with people who have experienced multiple circumstances of vulnerability, including in responding to family and domestic violence and suicidality.

There is much good work being done by State government departments and authorities to prevent men's vile and criminal violence against women and the trauma and tragedy that results from this violence, but we can and must do more.

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

The work of my Office in ensuring that the recommendations of the Investigation are given effect does not end with the tabling of this report. My Office will continue to monitor and report on the steps taken to give effect to the recommendations arising from the Investigation.

I acknowledge the ongoing effort of State government departments and authorities, our first responders, including police officers, child protection workers and health professionals, as well as non-government organisations, who work to keep victims safe and hold perpetrators accountable.

Finally, I extend my deepest personal sympathy and condolences to all Western Australian families, friends and communities impacted by the tragic and immeasurable loss of life of a loved one who has died by suicide. It is my sincerest hope that the recommendations of this investigation will contribute to preventing these tragic deaths in the future.

Chris Field
OMBUDSMAN

Table of Recommendations

Recommendation 1 That the Western Australia Police Force implement the recommended policy and practice reform proposed by Australia's National Research Organisation for Women's Safety (**ANROWS**) in its report on *Accurately identifying the "person most in need of protection" in domestic and family violence law*, including the development of guidance on:

- distinguishing between coercive controlling violence (physical and non-physical) and violence used in response to ongoing abuse;
- identifying patterns of coercive control;
- identifying the person most in need of protection in ambiguous circumstances; and
- determining whether a police order is necessary or desirable.

Recommendation 2: The Department of Justice consider the findings of this Investigation and continues to identify opportunities for community-based suicide prevention for women known to have been victims of family and domestic violence related crime including those:

- receiving support from court counselling and support services; and
- convicted of criminal offences and being managed in the community by Adult Community Corrections.

Recommendation 3: The Department of Communities, working together with relevant State government departments and authorities and stakeholders, identify strategies and practices for identifying, recording, and utilising information about children and adolescents' experiences of family and domestic violence. Including, but not limited to:

- the number of children affected by family and domestic violence in Western Australia;
- the nature of how children and adolescents experience family and domestic violence; and
- strategies, principles, and practices for collecting information about children affected by family and domestic violence.

Recommendation 4: That the Department of Communities consider and incorporate the findings of this investigation when undertaking the development and implementation of a 'Western Australian Family and Domestic Violence-Informed Approach,' regarding:

- the recording of family and domestic violence as a 'primary issue' or 'issue' in ASSIST;
- use of the outcomes 'Not departmental business' or 'Assessed as no further role' when family and domestic violence is identified; and
- the intake of interactions relating to family and domestic violence.

Recommendation 5: The Department of Communities, in order to better inform practice and policy, conducts a review and examines current data on:

- the presence of family and domestic violence in duty interactions concerning older children and adolescents;
- intake rates related to duty interactions concerning older children and adolescents, particularly where family and domestic violence is identified;
- policy, practice, and culture in relation to how the Department of Communities responds to older children and adolescents; and

provides the resulting review report to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this Investigation.

Recommendation 6: The Department of Communities, in consultation with key government and non-government stakeholders, considers this investigation and incorporates the findings of the investigation into strategic initiatives aimed at reducing the incidence and impact of suicide and self-harm associated with family and domestic violence, including incorporation into Path to Safety beyond the First Action Plan.

Recommendation 7: The Department of Communities, Western Australia Police Force and the Department of Justice, in consultation with key government and non-government stakeholders consider this investigation and incorporates the findings of this investigation in the redesign of the Family and Domestic Violence Response Team Model including, but not limited to:

- the association between family and domestic violence and suicide, for women and children;
- the association between family and domestic violence and suicide for Aboriginal and Torres Strait Islander women and children; and
- the need to see and speak to children and adolescents who are exposed to family and domestic violence when engaging with families and assessing risk, including those alleged to be the perpetrator or instigator of parent-child conflicts.

Recommendation 8: The Mental Health Commission, in collaboration with relevant State government departments and authorities and stakeholders, develop and disseminate a common understanding of what constitutes a trauma informed approach for Western Australian State government departments and authorities. Including, but not limited to:

- a definition and key principles of a trauma informed approach;
- domains of implementation (including, but not limited to, an organisation's strategic leadership, policy, training for staff, and evaluation);
- consideration of vicarious trauma in the service delivery context;
- this approach being intersectional, and elevates the voices and experiences of Aboriginal and/or Torres Strait Islander people; and
- a timeline for undertaking this work.

Recommendation 9: Taking into account the outcome of Recommendation 8, the Western Australia Police Force; the Department of Justice; the Department of Health; and the Department of Communities each:

- consider how a trauma informed approach may be incorporated into their operations; and
- work to improve their organisation's understanding of trauma.

Executive Summary

1 Introduction

Violence against women and children is a 'major public health problem and a violation of women's human rights' that is also preventable.[1]

Tragically, in this investigation, the Office of the Western Australian Ombudsman (**the Office**) has found that 56 per cent of the women who died by suicide in 2017 in Western Australia, had been recorded as a victim of family and domestic violence by a State government department or authority prior to their death.

Government agencies, through collaborative policy development and service provision, have a vital role to play in preventing suicide by women and child victims of family and domestic violence. Understanding the experiences of women and children who died by suicide and their interactions with State government agencies, is critical to improving public administration and the effectiveness of both family and domestic violence support services and suicide prevention efforts.

This Executive Summary outlines the role of the Ombudsman, the objectives and methodology of the investigation and a summary of the findings and recommendations.

Volume 2 of the investigation report, *Understanding the impact of family and domestic violence and suicide*, outlines the reasons why family and domestic violence increases the risk of suicide and self-harm in women and children, as identified in the research literature. It also explores what family and domestic violence looks like and feels like for victims and presents important context about family and domestic violence and suicide in Western Australia, including:

- definitions of family and domestic violence;
- coercive controlling behaviour;
- research examining the nature of family violence among Aboriginal and/or Torres Strait Islander people, families and communities; and
- research examining the impact of family and domestic violence upon children and adolescents.

Volume 3 of the investigation report, *Contact between victims of family and domestic violence who died by suicide and State government departments and authorities* details the Office's consideration of the deaths of 68 Western Australian women and children who were victims of family and domestic violence and died by suicide during the investigation period, and:

- includes an overview of state-wide Western Australia Police Force (**WA Police**) data relating to family and domestic incidents during between 1 January and 31 December 2017 (the investigation period);
- sets out how family and domestic violence is identified in the records of the WA Police Force, courts hearing restraining order proceedings, corrective services, hospitals and child protection services in Western Australia;

[1] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

- details the instances where records show that the 68 women and children who died by suicide had experienced repeat or persistent violence;
- sets out patterns of contact, including the time between the victim's most recent contact with each agency prior to their death; and
- explores differences in the patterns and trends between the 68 women and children State government departments and authorities.

Volume 4 of the investigation report, *The need for trauma informed responses*, identifies the current systemic responses to family and domestic violence provided by State government departments and authorities. It explores the need for agencies to continuously improve their focus on achieving safety for women and children and provide trauma-informed services to better meet their needs.

2 The role of the Ombudsman

The Parliamentary Commissioner for Administrative Investigations – more commonly known as the Ombudsman – is an independent and impartial officer of the Western Australian Parliament. The Ombudsman is responsible to the Parliament rather than to the government of the day or any Minister. This allows the Ombudsman to be independent in undertaking the Ombudsman's functions.

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

- receives, investigates and resolves complaints about State government agencies, local governments and universities;
- reviews child deaths and family and domestic violence fatalities;
- undertakes own motion investigations with all the powers of a standing Royal Commission; and
- undertakes a range of additional functions, including statutory inspection and monitoring functions.

2.1 The Ombudsman's family and domestic violence fatality review function

On 1 July 2012, the Office commenced an important new role to review family and domestic violence fatalities.

As outlined in Figure 1, WA Police informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death, together with any relevant information of prior WA Police contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family relationship' as defined by section 4 of the *Restraining Orders Act 1997* (**the *Restraining Orders Act***).

More specifically, the 'family relationship' between the person who was killed and the suspected perpetrator is a relationship between two persons:

(a) who are, or were, married to each other;
(b) who are, or were, in a de facto relationship with each other;
(c) who are, or were, related to each other;
(d) one of whom is a child who —
    (i) ordinarily resides, or resided, with the other person; or
    (ii) regularly resides or stays, or resided or stayed, with the other person;
(e) one of whom is, or was, a child of whom the other person is a guardian; or
(f) who have, or had, an intimate personal relationship, or other personal relationship, with each other.[2]

'Other personal relationship' means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person.

'Related', in relation to a person, means a person who:

(a) is related to that person taking into consideration the cultural, social or religious backgrounds of the 2 persons; or
(b) is related to the person's —
    (i) spouse or former spouse; or
    (ii) de facto partner or former de facto partner.[3]

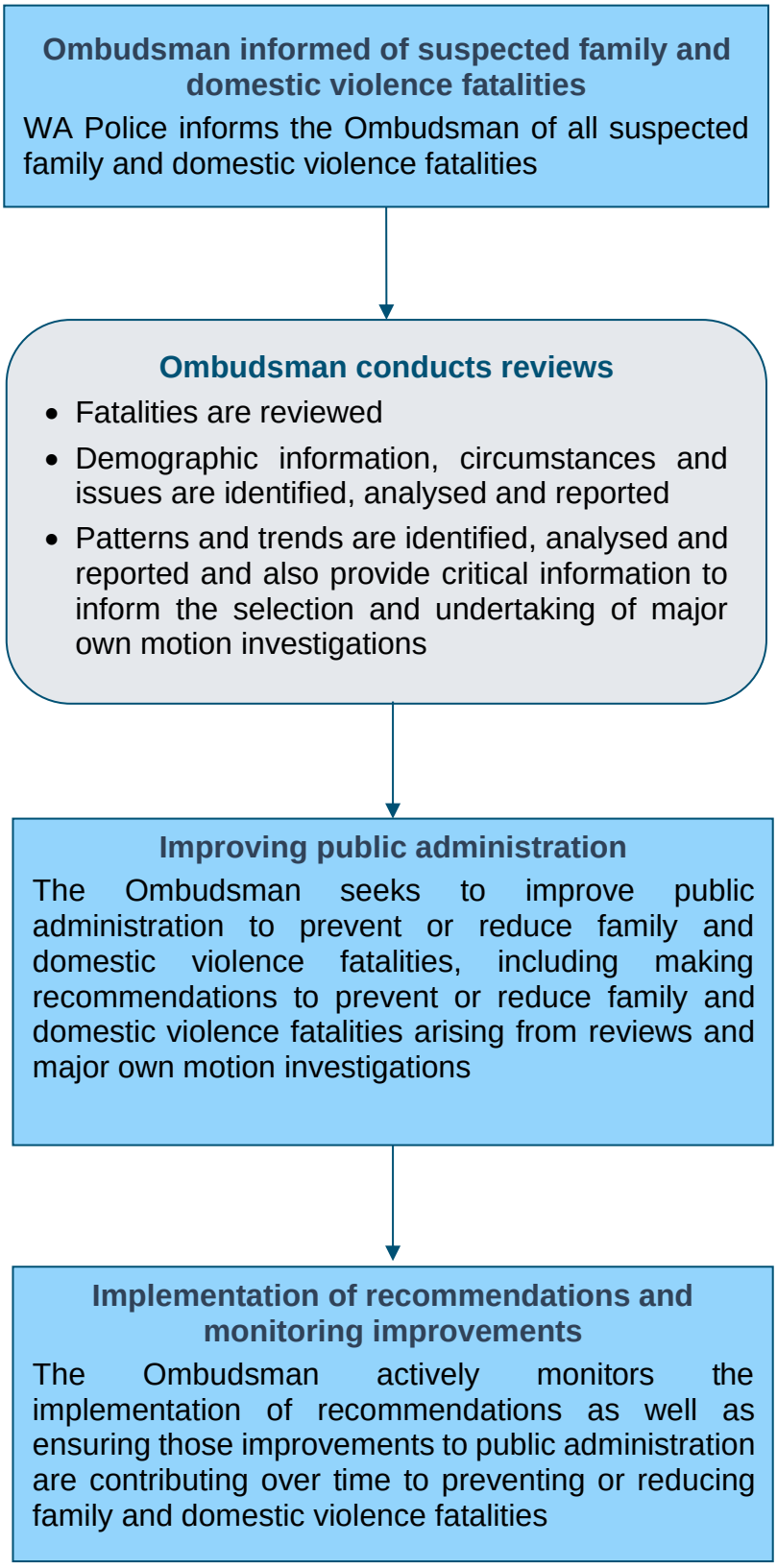
If the relationship meets these criteria, a review is undertaken.

The extent of a review depends on a number of factors, including the circumstances surrounding the death and the level of involvement of relevant public authorities in the life of the person who died or other relevant people in a family and domestic relationship with the person who died, including the suspected perpetrator. Confidentiality of all parties involved with the case is strictly observed.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the person who died; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

[2] *Restraining Orders Act 1997* (WA), s. 4(1).
[3] *Restraining Orders Act 1997* (WA), s. 4(2).

Figure 1: The Family and Domestic Violence Fatality Review Process



Source: Ombudsman Western Australia

2.2 The Ombudsman's child death review function

On 30 June 2009, amendments to the *Parliamentary Commissioner Act 1971* (**the Act**) commenced into effect, granting an important new child death review function to the Ombudsman. The child death review function enables the Ombudsman to review investigable deaths where the child, or their family, was known to the Department of Communities in the two years before the child's death as defined in section 19A(3) of the Act.

To facilitate the review of investigable deaths, the Department of Communities receives information from the State Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to the Department of Communities by the Coroner about the circumstances of the child or young person's death together with a summary outlining the past involvement of the Department of Communities with the child and their family.

In addition to reviewing investigable deaths, the Ombudsman can review other notified deaths and undertake major own motion investigations relating to child death reviews under section 16(1) of the Act. Each recommendation arising from an own motion investigation is actively monitored by the Office to ensure its implementation and effectiveness, in accordance with sections 25(4) and (5) of the Act.

2.3 Own motion investigations

Under section 16(1) of the Act, the Ombudsman is able to investigate, by her or his own motion, any administrative decision, recommendation or action by State government departments and authorities within his or her jurisdiction, as follows:

> Without prejudice to the provisions of section 15 any investigation that the [Ombudsman] is authorised to conduct under this Act may be so conducted, either on [her or his] own motion or on a complaint …

3 About the investigation

3.1 Objectives

The objectives of the investigation were to:

- examine the association between family and domestic violence and suicide as identified in the research literature, and among individuals who died by suicide;
- identify patterns and trends in the demographic characteristics and social circumstances of women and children who were victims of family and domestic violence and died by suicide and their contact with State government departments and authorities; and
- based upon this analysis, determine whether it may be appropriate to make recommendations to any State government department or authority.

3.2 Methodology

To undertake the own motion investigation, the Office:

- conducted a review of relevant national and international literature relating to the association between family and domestic violence and suicide (which is referred to as **the research literature** throughout this report);
- collected information and data from State government departments and authorities about each of the 410 people who died by suicide during the investigation period;
- analysed the information and data relating to the 410 people who died by suicide using qualitative and quantitative techniques to identify women and children who were victims of family and domestic violence and died by suicide within the 410 people;
- identified that 68 women and children were victims of family and domestic violence and died by suicide, this includes 20 children and young women aged under 26;
- undertook extensive analysis of the circumstances of the 68 women and children who were victims of family and domestic violence and died by suicide;
- undertook analysis of two further sub-groups of the 410 people, namely Aboriginal and Torres Strait Island people and children and young women;
- consulted with government and non-government organisations;
- consulted relevant stakeholders regarding the results of our analysis as well as engaging external professionals with expertise regarding suicide and family and domestic violence to critically comment and review the data collection and analysis and the draft findings that arose from this analysis;
- developed a draft report containing preliminary opinions and draft recommendations and provided it to relevant State government departments and authorities for their consideration and comment; and
- prepared the final report and recommendations.

4 Definitions and language used in this report

Throughout the investigation, including during consultation with stakeholders and the review of the research literature, the use of language has been raised as an important issue.

Aboriginal and/or Torres Strait Islander

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

The terms 'Aboriginal' and 'Torres Strait Islander' are used to describe the identity of people who have died by suicide. When referring to a group of people including both Aboriginal people and Torres Strait Islander people, we use the phrase 'Aboriginal and Torres Strait Islander people'. We also use the term 'Aboriginal and/or Torres Strait Islander' when referring to the population.

In tables, Aboriginal and/or Torres Strait Islander individuals are identified as **ATSI individuals.**

Aboriginal family violence

Where the Office is specifically discussing family and domestic violence in relation to Aboriginal and/or Torres Strait Islander Western Australians, where appropriate, the Office has used the term 'family violence'. In the work of the Office, Aboriginal and Torres Strait Islander stakeholders have indicated to the Office that this is the preferred terminology, particularly as it recognises the importance of extended kinship and family networks to Aboriginal and Torres Strait Islander people. However, it is important to note that 'the use of this term [does] not obscure the fact that Aboriginal [and Torres Strait Islander] women and children bear the brunt of family violence'.[4]

Family violence involves any use of force, be it physical or non-physical, which is aimed at controlling another family or community member and which undermines that person's well-being. It can be directed towards an individual, family, community or particular group. Family violence is not limited to physical forms of abuse, and also includes cultural and spiritual abuse. There are interconnecting and trans-generational experiences of violence within Indigenous families and communities.[5]

Aboriginal and/or Torres Strait Islander researchers and experts identify that there are 'multiple complex and diverse factors contributing to the high levels and severity of family violence in Aboriginal and Torres Strait Islander communities,'[6] and 'it must be clearly understood that the causes do not derive from Aboriginal culture. Family violence is not part of Aboriginal culture.'[7]

The drivers of family violence for Aboriginal and/or Torres Strait Islander individuals are distinct and multifaceted and cannot be conceptualised without examining the history of

[4] Department for Child Protection and Family Support, *Family and Domestic Violence Background Paper*, 2012, Government of Western Australia, Perth, p. 2.
[5] Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 – 2006*, 2006, Human Rights and Equal Opportunity Commission, p. 6.
[6] Aboriginal Family Violence Prevention & Legal Service Victoria, 'Submission to the Victorian Royal Commission into Family Violence,' 2015, FVPLS Victoria, Melbourne, p. 22.
[7] Aboriginal Family Violence Prevention & Legal Service Victoria, 'Submission to the Victorian Royal Commission into Family Violence,' 2015, FVPLS Victoria, Melbourne, p. 22.

Aboriginal and/or Torres Strait Islander peoples following colonisation. Aboriginal and/or Torres Strait Islander perspectives highlight the causes of family violence as 'located in the history and impacts of white settlement,' and 'structural violence of race relations since then.'[8] Family violence is examined in further detail in section 1.2 of Volume 4 of this report.

Family and domestic violence

The term 'family and domestic violence' or 'family violence' is used to refer to the relationships identified under section 4 of the *Restraining Orders Act 1997*, and the behaviours specified in section 5A of the *Restraining Orders Act 1997*. The definition of family and domestic violence is discussed in further detail at section 1.1 of Volume 4 of this report.

The Office recognises that the terms 'family and domestic violence' and 'family violence' can be 'mutualising',[9] that is, these terms could mean that everyone in a family, or a number of members of a family, were, or are, violent to each other. Where appropriate, the Office has included information about who perpetrated the violence, and who was the victim of the violence.

In tables, family and domestic violence is referred to as **FDV**.

Gendered language

Much of the research literature and key Australian and Western Australian reports commonly identify family and domestic violence as involving male perpetrators and female victims, in recognition that family and domestic violence has an 'unequal impact on women,'[10] and is 'grounded in gender inequality.'[11] While some literature identifies 'this is not intended to suggest that men are never victims or that women are never perpetrators' of family and domestic violence, family and domestic violence 'predominantly affects women and children.'[12]

[8] Aboriginal Affairs Victoria, *Strong Culture, Strong Peoples, Strong Families Towards a safer future for Indigenous families and communities*, 2008, Victorian Government, p. 12.
[9] Coates L and Wade A, *National Crime Victims Awareness Week "Choose Your Words Carefully"*, PowerPoint presentation delivered in Ottawa, Canada, 19 April 2010.
[10] Council of Australian Governments, *National Plan to Reduce Violence against Women and their Children 2010 – 2022*, 2011, viewed 18 September 2020, <http://www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children>.
[11] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, p. 51.
[12] AVERT Family Violence, *Prevention Strategies: Involving and Engaging Perpetrators*, Australian Government, Canberra, 2010, p. 5.

Sex

The ABS identifies that although the terms sex and gender are interrelated and often used interchangeably, 'they are two distinct concepts,' in particular:

> **…** a person's **sex** is based upon their sex characteristics, such as their chromosomes, hormones and reproductive organs. While typically based upon the sex characteristics observed and recorded at birth or infancy, a person's reported sex can change over the course of their lifetime and may differ from their sex recorded at birth … [and]
>
> **Gender** is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, woman or non-binary person. Non-binary is an umbrella term describing gender identities that are not exclusively male or female.[13]

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.[14]

The personal challenges and experiences of people 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.'[15] For this reason, the Office has sought to use inclusive terminology throughout this report when discussing gender identity.

The Office also acknowledges that:

- our data with respect to the gender identity of individuals (as drawn from the records of State Government departments and authorities) is unlikely to be complete, and many agency data collection systems and processes do not yet facilitate the recording of gender identity beyond a binary male/female format;
- comparable population data relating to self-harm and suicide, and variables relating to family and domestic violence published by agencies such as the ABS is currently only reported with reference to biological sex; and
- qualitative and quantitative data examined in the research literature relating to family and domestic violence and suicide is predominantly 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). Further, we use the word 'gender' to refer to a person's

[13] Australian Bureau of Statistics, *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables*, January 2021, viewed 4 November 2021 <https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release>.
[14] 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*, 2018, p. 12.
[15] 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*, 2018, p. 12.

self-described gender identity, where this is recorded as part of the records obtained during this investigation.

In this report, we also use the words 'men and boys' and 'women and girls' as meaning:

- **men and boys**: persons recorded as displaying primarily male or masculine biological characteristics, or as male sex assigned, where this accords with a person's self-described gender identity, in addition to those recorded with female or feminine biological characteristics or as female sex assigned at birth, who self-identify as being male.
- **women and girls**: persons recorded as displaying primarily female or feminine biological characteristics, or as female sex assigned, where this accords with a person's self-described gender identity, in addition to those recorded as having male biological characteristics or sex assigned at birth who self-identify as being female.

Suicide

Suicide is defined as 'the intentional taking of one's life.'[16]

The 410 people who died by suicide

The Office analysed 410 deaths that occurred between 1 January 2017 and 31 December 2017 in which a 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, these people are referred to as **the 410 people who died by suicide**.

From the 410 people who died by suicide, the Office then analysed the deaths of 68 women and children who were victims of family and domestic violence and died by suicide between 1 January 2017 and 31 December 2017. These women and children are referred to as **the 68 women and children**. Included in the 68 women and children, the Office identified 20 children and young women aged under 26 who died by suicide. These children and young women are referred to **the 20 children and young women**.

The investigation period

During this investigation, the Office considered the 410 Western Australians who died by suicide between 1 January 2017 and 31 December 2017. Throughout this report, we refer to these dates as **the investigation period**.

Children

In this report, the term 'children' is used when referring to children aged 0-17 years unless specified otherwise.

[16] Mendoza J and Rosenberg S, *Suicide and Suicide Prevention in Australia: Breaking the Silence*, 2010, Lifeline Australia and Suicide Prevention Australia, p. 12.

Adolescents

In this report, the term 'adolescents' is used to refer to children aged between 14 and 17 years unless specified otherwise.

Young adults

In this report, the term 'young adults' is used to refer to individuals aged 18 to 25 years at the time of their death.

Victim and perpetrator

Throughout this report, the Office uses the terms 'victim' and 'perpetrator', which are commonly used in the research literature.

These terms are also consistent with key national and state reports, for example the Council of Australian Government's *National Plan to Reduce Violence against Women and their Children 2010 – 2022*[17] and *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030.*[18]

The term 'victim' is used in acknowledgement of the harm caused by family and domestic violence 'and is not reflective of the person's full identity'.[19]

The term 'perpetrator' is used when identifying individuals who have used violence and inflicted harm within their family relationships and 'is not reflective of the person's identity or capacity for change.'[20]

[17] Council of Australian Governments, *National Plan to Reduce Violence against Women and their Children 2010 – 2022*, 2011, Australian Government, viewed 18 September 2020, <http://www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children>.
[18] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth.
[19] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth, p. 51.
[20] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth, p. 51.

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5 Volume 2: Understanding the impact of family and domestic violence and suicide

Volume 2 of the investigation report, *Understanding the impact of family and domestic violence and suicide*, outlines the reasons why family and domestic violence increases the risk of suicide and self-harm in women and children, as identified in the research literature. It also explores what family and domestic violence looks like and feels like for victims and presents important context about family and domestic violence and suicide in Western Australia, including:

- definitions of family and domestic violence;
- coercive controlling behaviour;
- research examining the nature of family violence among Aboriginal and/or Torres Strait Islander people, families and communities; and
- research examining the impact of family and domestic violence upon children and adolescents.

Volume 2 contains the thematic findings of the Office's extensive literature review regarding family and domestic violence and suicide, as summarised below.

5.1 Suicide is preventable

Suicide can be prevented, as highlighted by the World Health Organization, the United States Centers for Disease Control and Suicide Prevention Australia.[21] Government departments and authorities have a key role in preventing suicide in our community, and there 'is the potential at every level and across each portfolio to identify aspects of suicide prevention that relate to existing responsibilities.'[22]

5.2 Many complex factors can influence suicide risk, or create safety and prevent suicide

The research literature offers no simple explanations for suicide, with scientific evidence highlighting a range of risk factors for suicide and suicidal behaviour including mental illness, previous self-harm or suicide attempts, substance abuse disorders, adverse childhood experiences, and stressful life events or crises.[23] Effective suicide prevention requires a whole of government approach to address the 'social, economic, health, occupational, cultural, and environmental factors' that can lead a person to significant distress and suicidal behaviours.[24]

[21] World Health Organization, *Key facts: Suicide*, 17 June 2001, <https://www.who.int/news-room/fact-sheets/detail/suicide>; Stone DM, Holland KM, Bartholow B, Crosby AE, Davis S, and Wilkins N, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control*, 2017, Centers for Disease Control and Prevention; Suicide Prevention Australia, 'Our ambition', <https://www.suicidepreventionaust.org/our-ambition/>.
[22] National Suicide Prevention Taskforce, *Final Advice: Connected & Compassionate – Implementing a national whole of governments approach to suicide prevention*, Australian Government, December 2020, p 1.
[23] MacIsaac M, Bugeja L, and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61; Fuller-Thomson, Baird SL et al, 'The association between adverse childhood experiences (ACEs) and suicide attempts in a population based study,' *Child: care, health and development*, 42(5), p. 725; and Commission for Children and Young *People (Victoria), Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 8.
[24] Suicide Prevention Australia, *2022-23 Pre-Budget Submission*, January 2022, p 11.

Although commonly used, suicide 'risk assessment tools' linking demographic risk factors to suicide risk have been found by a British Medical Journal 'state of the art' review of suicide risk assessment and intervention as having been developed without a solid evidence base.[25]

There is, however, 'strong evidence' which demonstrates that 'the risk of suicide among those who have self-harmed is much greater than that of the general population.'[26] Those bereaved by suicide are also recognised as being at elevated risk of suicide, including those who may need support but are 'less visible, such as children, ex-partners, and more peripheral friends, … [who] can experience disenfranchised grief that is not socially sanctioned or openly acknowledged.'[27]

The Australian Institute of Health and Welfare (**AIHW**) has noted that 'risk factors relating to deaths by suicide can highlight areas of a person's life experience that may need additional attention [however] … the presence of one or more of these risk factors in an individual's life does not necessarily mean they will have suicidal behaviours.'[28]

For Aboriginal and Torres Strait Islander people, there are additional risk factors and impacts affecting both suicide risk and the effectiveness of suicide prevention interventions. Suicide among Aboriginal and Torres Strait Islander peoples 'was almost unheard of prior to the 1960s.'[29] The *Wiyi Yani U Thangani Report* identifies that 'there appears to be a relatively low correlation between Aboriginal suicide and diagnosable mental illness, where drug and alcohol misuse is considered separately' and that the 'disproportionate rate of suicide in Aboriginal and Torres Strait Islander populations is in part attributed to higher levels of social and economic disadvantage, and increased exposure to known risk factors shared with the general population such as poverty, unemployment, homelessness, incarceration and family violence.'[30]

5.3 Violence against women and children is a 'major public health problem and a violation of women's human rights' that is also preventable

As noted by the World Health Organization, violence against women and children is a highly prevalent, worldwide, preventable social problem, with 'about 1 in 3 (30%) of women worldwide … subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime'.[31]

Children living in homes with violence can 'suffer a range of behavioural and emotional disturbances … [and] higher rates of infant and child mortality and morbidity (through, for example diarrhoeal disease or malnutrition and lower immunization rates'.[32]

[25] Bolton JM, Gunnell D and Turecki G, 'Suicide risk assessment and intervention in people with mental illness', BMJ, 2015;351:h4978 <http://dx.doi.org/10.1136/bmj.h4978>.
[26] Royal College of Psychiatrists, *Self-harm and suicide in adults: Final report of the Patient Safety Group* (CR229), July 2020, p 30 - 31.
[27] Royal College of Psychiatrists, *Self-harm and suicide in adults: Final report of the Patient Safety Group* (CR229), July 2020, p 57.
[28] Australian Institute of Health and Wellbeing, *Suicide & self-harm monitoring: Psychosocial risk factors and deaths by suicide*, viewed 28 May 2022, <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide>.
[29] Dudgeon P, Cox A, Walker R, et al, *Solutions that Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*., 2016, School of Indigenous Studies, UWA, Perth, p. 6.
[30] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, AHRC, Canberra, 2020, p. 433.
[31] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.
[32] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

5.4 Suicidal behaviour is highest among women and girls, who attempt suicide more frequently but die less frequently than men and boys

National statistics and studies on suicidal behaviour have consistently shown that women and girls engage in suicidal behaviour much more frequently than men and boys, although they are less likely to die from suicide than men.[33] The Australian Institute of Health and Wellbeing observes that the morbidity burden associated with women and girls' suicidal behaviour has grown markedly in recent years, with 'males … more likely than females to die by suicide, [but] females … more likely to be hospitalised for intentional self-harm (1.75 times).'[34]

Historically, there have been few studies on suicide focussed on suicidal behaviour in women and its association with gender differences, vulnerabilities, or psychosocial stressors, with some attempting to explain this research gap as arising from 'a tendency to view suicidal behavior in women as manipulative and nonserious (despite evidence of intent, lethality, and hospitalization), to describe their attempts as "unsuccessful," "failed," or attention-seeking, and generally to imply that women's suicidal behavior is inept or incompetent.'[35]

5.5 Suicide is linked to experiences of violence and injury, including gender-based violence, family and domestic violence, sexual abuse, physical abuse and abuse in childhood

Despite historical violence prevention research and prevention focussing on particular forms of violence, such as physical abuse, sexual abuse, psychological abuse and neglect, the United States Centres for Disease Control have long observed the need for a cross-cutting, strategic approach to preventing multiple forms of violence, due to the strong connection and relationship between them, including that:

- Those who are victims of one form of violence are likely to experience other forms of violence.
- Those who have been violent in one context are likely to be violent in another context.
- The different forms of violence share common consequences. Beyond physical injuries and deaths these include a broad range of mental, emotional and physical health, and social problems that have effects across the lifespan.
- The evidence also clearly shows that the different forms of violence share common risk and protective factors.[36]

Across Australia, research and reviews jurisdictions have identified an association between family and domestic violence and suicide, including in Queensland, where the Domestic and Family Violence Death Review and Advisory Board has observed that 'the relationship between suicidal ideation, threats and attempts, and violence perpetration within intimate

[33] Australian Institute of Health and Wellbeing, *Injury in Australia: Intentional self-harm and suicide*, 9 December 2021 <https://www.aihw.gov.au/reports/injury/intentional-self-harm-and-suicide>; Devries K, Watts C, Yoshihama M et al, 'Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women', 2011, *Social science & medicine,* 73(1), p. 79-86.
[34] Australian Institute of Health and Wellbeing, *Australia's health 2020: Suicide and intentional self-harm*, 23 July 2020, <https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm>.
[35] Vijayakumar L, 'Suicide in women'," *Indian journal of psychiatry*, 2015, vol. 57,Suppl 2: S233-8. doi:10.4103/0019-5545.161484.
[36] Centres for Disease Control, *Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots. Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control*, 2016, p. 4-5.

partner or family relationships is not well understood, particularly its association with subsequent lethality … in part because of a paucity of research in this area.[37]

5.6 There is a strong relationship between family and domestic violence and suicidality identified in the research literature

In responding to the need to advance knowledge and understanding, and to mitigate limitations in available research, researchers have undertaken systematic reviews that aim to identify, evaluate, and summarise individual studies undertaken concerning the relationship between family and domestic violence and suicide.

Importantly, in acknowledging the limitations of existing, individual studies, systematic reviews have nonetheless identified 'a strong and consistent association between intimate partner abuse and suicidality.'[38] This relationship has been identified to hold 'irrespective of method, sample and measurement of [intimate partner violence/abuse] and suicidality' with 'the degree of consistency in findings across these studies confirm[ing] a strong relationship between [intimate partner violence/abuse] and suicidality [and for] … intimate partner abuse [as] a significant risk factor for suicidal thoughts and behaviours.'[39]

Additionally, the relationship appears to extend beyond violence in the context of intimate partner relationships, with a recent systematic review identifying that 'being a victim or perpetrator of violence appears to be associated with risk of suicide.'[40]

The association between family and domestic violence and suicide has been examined in other Australian jurisdictions. Crucially, this work is also based upon broad and inclusive definitions of family and domestic violence, with:

- the Queensland Domestic and Family Violence Death Review and Advisory Board identifying that 'apparent suicides contribute the largest number of domestic and family violence deaths each year in Queensland' and that 'intimate partner violence is a significant risk factor for suicide in female victim/survivors, with some studies suggesting women who have been abused by their intimate partners are almost four times more likely to experience suicidal ideation compared to non-abused women in the general population;'[41]
- the New South Wales Domestic Violence Death Review Team identifying that almost half of female suicides examined in a pilot study 'had a recorded or apparent history of domestic and family violence, relationship conflict or relationship breakdown' (49 per cent);[42] and
- Victorian research identifying that 'forty-two percent of women who died from suicide had a history of exposure to interpersonal violence.'[43]

[37] Queensland Domestic and Family Violence Death Review and Advisory Board, 'Domestic and family violence death of 'Frank,' 2017, Queensland Government, Brisbane, p. 14-15.
[38] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 677.
[39] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 685.
[40] MacIsaac M, Bugeja L and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61.
[41] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, Queensland Government, Brisbane, 2021, p. 1.
[42] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2017-2019*, New South Wales Government, Sydney, 2019, p. 140.
[43] MacIsaac M, Bujega L, Weiland T et al, 'Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia,' *Asia Pacific Journal of Public Health,* 2018, 30(1), p. 36.

Aboriginal and/or Torres Strait Islander researchers have also identified that family violence and suicide are connected, with family violence 'disrupt[ing] healthy connections to family and has long-term negative impacts on mental health and wellbeing of children and their mothers,' and 'mak[ing] children more vulnerable to suicide and suicide-related behaviour.'[44]

5.7 Family and domestic violence is gendered violence and criminal behaviour perpetrated against women and children

Family and domestic violence is gendered violence and criminal behaviour perpetrated against women and children and 'is a violent crime perpetrated by men against women and children that 'tears lives apart.'[45]

Each week in Australia, on average, one woman is killed by her current or former partner.[46]

Women are most likely to experience violence from someone they know (often a current or a previous partner) in their own home. In contrast, men are most likely to experience violence in public from a stranger.[47]

Recognising the gendered nature of family and domestic violence and its relationship with historic and current systemic misogyny and sexism and the structural social, political and economic inequality of women (and the role of men in causing and perpetrating this inequality) is an essential, indeed inseparable, element for ensuring successful service systems, policies and responses to family and domestic violence.[48] It is also important to recognise that 'individual stories of courage, hope and resilience form the backdrop of these statistics.'[49]

5.8 Family and domestic violence includes non-physical, coercive controlling behaviours

The United Nations *Declaration on the Elimination of Violence against Women* defines violence against women as 'any act of gender-based violence that causes or could cause physical, sexual or psychological harm or suffering to women, including threats of harm or coercion, in public or in private life.'[50]

In 2017, the UN Committee for the Elimination of Discrimination against Women adopted Recommendation No. 35 on gender-based violence against women, which defines 'gender-based violence against women' as taking 'multiple forms, including acts or omissions intended or likely to cause or result in death or physical, sexual, psychological, or economic harm or suffering to women, threats of such acts, harassment, coercion, and arbitrary

[44] Dudgeon P, Blustein S, Bray A, et al, *Connection between family, kinship and social and emotional wellbeing*, 2021, Indigenous Mental Health and Suicide Prevention Clearinghouse, Australian Institute of Health and Welfare, Canberra, p. v.
[45] NSW Government Communities and Justice, *The effects of domestic and family violence*, September 2019, viewed 18 February 2022, <https://www.facs.nsw.gov.au/domestic-violence/about/effects-of-dv>.
[46] Australia's National Research Organisation for Women's Safety, *Violence against women: Accurate use of key statistics (ANROWS Insights 05/2018)*, 2018, ANROWS, Sydney; Cussen T & Bryant W, *Domestic/family homicide in Australia (Research in practice, no. 38),* 2015, Australian Institute of Criminology; Bryant W & Bricknell S, *Homicide in Australia 2012-13 and 2013-14: National Homicide Monitoring Program report*, 2017, Australian Institute of Criminology, Canberra.
[47] Australian Institute of Health and Welfare, *Family, domestic, and sexual violence in Australia,* 2018, viewed 18 February 2022, <https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/summary>.
[48] Poon J, Dawson M & Morton M, 'Factors increasing the likelihood of sole and dual charging of women for intimate partner violence', *Violence Against Women*, 2014, 20(12), 1447–1472; Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law* (Research report, 23/2020), 2020, ANROWS; Nancarrow H, *Unintended consequences of domestic violence law: Gendered aspirations and racialised realities*, 2019, Springer Nature.
[49] Australia's National Research Organisation for Women's Safety, *Violence against women: Accurate use of key statistics (ANROWS Insights 05/2018),* 2018, ANROWS.
[50] United Nations General Assembly, *Declaration on the Elimination of Violence against Women* (1993), viewed 18 February 2022, <https://digitallibrary.un.org/record/179739?ln=en>.

deprivation of liberty' which may occur in 'all spaces and spheres of human interaction, … [including] the family, the community, the public spaces, the workplace, leisure, politics, sport, health services, educational settings and … contemporary forms of violence occurring in the Internet and digital spaces.'[51]

For the purposes of this investigation, in using the term 'family and domestic violence', the Office refers to the relationships and behaviours specified in the *Restraining Orders Act 1997* (WA). Section 5A of the *Restraining Orders Act* recognises a range of violent, threatening, coercive, controlling and fear-inducing behaviours beyond physical abuse as 'family violence', including sexual, emotional, psychological and financial abuse.[52]

5.9 Coercive control is the context in which family and domestic violence occurs

Family and domestic violence is not solely made up of discrete, isolated incidents of violence.[53] Power and control are central to understanding family and domestic violence. These concepts are 'well understood by those who have experienced it' and have been expressed in recent research literature using the concept of 'coercive control'.[54] Coercive control, is the relentless pattern of behaviour and 'tactics to isolate, degrade, exploit … frighten or hurt [victims] physically' specifically targeting and responding to a victim-survivor, with the aim of controlling their life.[55]

Coercive control is ongoing, insidious, and 'almost exclusively perpetrated by men against women.'[56] Coercive controlling behaviours are 'not simply an action within a list of other actions that may constitute DFV [domestic and family violence], but is the *context* in which DFV occurs.'[57]

Coercive control is 'commonly described by victim-survivors as the worst form of abuse they experience' that can be 'hostage-like' in the harmful way it erodes a person's safety, wellbeing, confidence, self-esteem, 'autonomy and personhood, as well as to physical and psychological integrity'.[58] These effects have been described as 'intimate terrorism', leaving 'emotional and psychological scars [that] are not immediately visible.'[59]

[51] United Nations Committee on the Elimination of Discrimination against Women, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, 14 July 2017 CEDAW/C/GC/35.
[52] *Restraining Orders Act 1997* (WA), s 5A(2)-(3).
[53] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 93.
[54] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 47.
[55] Stark E, 'Re-representing Battered Women: Coercive Control and the Defense of Liberty,' prepared for Violence Against Women Complex Realities and New Issues in a Changing World Conference, Montreal, 2012, viewed 9 October 2020 <http://www.stopvaw.org/uploads/evan_stark_article_final_100812.pdf>.
[56] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 40.
[57] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 2.
[58] Parliament of Australia, House of Representatives Standing Committee on Social Policy and Legal Affairs, *Final Report: Inquiry into family, domestic and sexual violence*, March 2021, Commonwealth of Australia, p. 11, viewed 18 June 2022, <https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Report/section?id=committees%2Freportrep%2F024577%2F75463>.
[59] Healthtalk, *Women's experiences of Domestic Violence and Abuse: Emotional-psychological abuse and effects on women's self-esteem*, February 2020, viewed 18 February 2022 < https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/emotional-psychological-abuse-and-effects-on-womens-self-esteem>.

5.10 Family and domestic violence can have devastating effects

Family and domestic violence can have devastating effects. Each and every woman that experiences family and domestic violence has a unique and individual experience, and 'the individual and cumulative impact of each act of violence depends on many complex factors.'[60]

Family and domestic violence seriously affects women's health and causes more illness, disability and deaths than any other risk factor for women aged 25–44, including smoking, alcohol and obesity.[61] The health impacts of family and domestic violence include 'injuries and homicide, poor mental health, reproductive health problems and problems with alcohol and drug use.'[62]

Violence against women and children can also significantly impact on their short and long-term health, wellbeing, education, relationships and housing outcomes.[63]

Communities, governments and businesses also suffer the effects of family and domestic violence, with the estimated total annual cost of this violence in Australia during 2015-16 being $22 billion.[64]

5.10.1 Some women and children are more vulnerable to family and domestic violence

Aboriginal and Torres Strait Islander women, young women, pregnant women, women separating from their partners, women with disability, older women, women from culturally and linguistically diverse backgrounds, LGBTIQ+ people, women living in rural and remote areas, and women experiencing socioeconomically disadvantage and women financial hardship are at greater risk of family, domestic and sexual violence.[65]

Children and Aboriginal and Torres Strait Islander women are particularly vulnerable to family and domestic violence in Western Australia, and for this reason are the subject of separate consideration, where relevant, in this investigation.

5.10.2 Perpetrators seek to avoid accountability for their violence and may manipulate institutions to maintain control or inflect abuse

The research literature suggests that perpetrators of family and domestic violence will take steps to avoid being held accountable for their behaviour, including instances where perpetrators may present the violence as mutual or joint, both to avoid responsibility and to shift responsibility to the victim. [66] This includes where perpetrators describe violence as an 'argument' or 'retaliation'.[67]

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[60] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3, AIHW, Canberra.
[61] Ayre J, Lum On M, Webster K, Gourley M, & Moon L, *Examination of the burden of disease of intimate partner violence against women in 2011: Final report*, 2016, ANROWS, p. 9.
[62] Webster K, 'A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: *Key findings and future directions,'* 2016, Australia's National Research Organisation for Women's Safety, Sydney.
[63] Ayre J, Lum On M, Webster K et al, *Examination of the burden of disease of intimate partner violence against women in 2011: Final report*, 2016, ANROWS, p. 9.
[64] KPMG, *The cost of violence against women and their children in Australia: Final detailed report*, 2016, Sydney, NSW.
[65] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3. AIHW, Canberra, p. 70.
[66] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, Perth, p. 12.
[67] Chung D, Green D, Smith G et al, *Breaching Safety: Improving the Effectiveness of Violence Restraining Orders for Victims of Family and Domestic Violence*, 2014, The Women's Council for Domestic and Family Violence Services, Perth, p. 11.

Examples of strategies used by perpetrators to manipulate institutions and maintain control over a victim include:

- Threatening to call Child Protective Services … and making actual reports that his partner neglects or abuses the children.
- Changing lawyers and delaying court hearings to increase his partner's financial hardship.
- Telling police officers she hit him, too.
- Giving false information about the criminal justice system to confuse his partner or prevent her from acting on her own behalf.[68]

The Department of Communities has specifically identified the risk of 'collusive practice' in its resource materials for officers engaging with perpetrators:

> Men who perpetrate violence can be persuasive and subtle in the ways they downplay, deny, justify and rationalise their behaviour. Furthermore, they hold implicit beliefs—about women, relating to women and relationships—that enable them to feel right and vindicated regarding their behaviours and to perceive themselves as the victim in their interpersonal relationships.
>
> When you are trying to engage a perpetrator of family and domestic violence, it is very likely that he will try to get you to collude with his narrative about the violence, perhaps by:
>
> - presenting as calm, collected and reasonable;
> - presenting his (ex)partner as irrational, unreasonable or mentally ill;
> - lying about or omitting known facts, or presenting a partial picture;
> - claiming his partner is lying or fabricating evidence;
> - claiming 'the system' is out to get him;
> - speaking on behalf of his (ex)partner—especially if he is her carer;
> - claiming the violence is mutual;
> - acknowledging some wrongs while not accepting responsibility; or
> - attempting to use humour or other forms of charm to win you over.[69]

5.10.3 Victims of family and domestic violence act to resist violence perpetrated against them and protect their children

The research literature identifies that victims of family and domestic violence will use a wide array of strategies to resist and respond to violence, and that the way in which victims respond to and resist violence depends upon the dangers and opportunities of their specific circumstances.[70]

[68] Alabama Coalition Against Domestic Violence, *Why do Abusers Batter?*, Alabama Coalition Against Domestic Violence, cited by Ombudsman Western Australia *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, 2015, p. 129.
[69] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, p. 47-48.
[70] For example, Wilson, D, Smith, R, Tolmie, J and de Haan, I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, p. 28.

Researchers in the area of family and domestic violence further identify that some strategies employed by victims may create the perception that a victim is also a perpetrator of violence or not responding in a way that may align with expectations, such as 'fighting back or defying the [perpetrator],' or using or abusing substances as an 'escape' or to numb physical pain.[71] Researchers identify that for some victims use of force is 'not always defensive … often it is more aptly described as "violent resistance"', insofar as some women will respond to a violent partner with violence to stop or reduce the violence, or through 'anger, frustration or retaliation.'[72]

Researchers identify that these factors influence police decision making.[73] In 2010, the Australian Law Reform Commission observed that, if police 'fail to identify the "primary aggressor" and the "primary victim" when attending a scene of family violence … this may mean that victims are wrongly charged with family-violence related offences and inappropriately having protection orders taken out against them.'[74]

5.10.4 Women are misidentified as a perpetrator of family and domestic violence

In Australia, each State and Territory has introduced laws attempting to address the harmful effects of family and domestic violence on women and to enable them to seek protection from harm occurring in the future.[75]

The difficulty experienced by police in determining who is the 'person most in need of protection' when attending call outs relating to family and domestic violence, can lead to misidentification of 'women who use violence in response to abuse' as suspected perpetrators of abuse, particularly when there are 'mutual allegations of violence.'[76]

Misidentification of women as perpetrators of violence has 'wide-ranging, harmful (even life-threatening) and long-term' impacts including re-victimisation of victims, homelessness, criminal justice outcomes, and can undermine and compromise victim safety.[77]

5.10.5 Most family and domestic violence is not reported

Most women who have experienced physical or sexual violence from a partner do not seek advice or support from the police (82%), and with many also reluctant to turn to informal networks of friends or family for support (46%).[78] Accordingly, the numbers of women and children experiencing family and domestic violence are likely to be significantly higher than

[71] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 28.
[72] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[73] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[74] Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, Australian Government, Canberra, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[75] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, Sydney.
[76] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, Sydney.
[77] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 30-31.
[78] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story 2019—In brief*, 2019, cat. no. FDV 4, AIHW Canberra, p. ix.

the number captured by administrative data, due to the general underreporting of this type of abuse, with the World Health Organization highlighting that:

> A large proportion of interpersonal violence is unreported to criminal justice agencies, often because individuals fear stigma (e.g. from family and friends) or retribution from abusers for revealing their abuse. … . In addition, many victims will not disclose their situation unless they are directly asked.[79]

Sexual violence within family and domestic violence relationships 'is one of the most under-reported tactics of DFV and is a significant indicator of escalating frequency and severity of DFV.'[80]

5.11 Understanding the impact of family and domestic violence on children

5.11.1 Families are the primary source of a child's safety

Research identifies that families 'are a child's single most important environment in terms of influence on development,' 'with family relationships and interactions being critically important.'[81]

Families play a primary role in child caregiving, protection, and in the prevention of violence against children,[82] often representing 'a first layer of a child's protective environment.'[83] International human rights instruments recognise the family as 'the natural and fundamental group unit of society,'[84] with the right to family unity, protection and assistance entrenched in universal and regional human rights instruments, and international humanitarian law.[85]

The primacy of the family is also enshrined in the Council of Australian Government's *National Framework for Protecting Australia's Children 2009-2020,* which is underpinned by the principle that 'the safety and wellbeing of children is primarily the responsibility of their families, who should be supported by their communities and governments.'[86]

[79] WHO, Reducing violence through victim identification, care and support programmes. (Series of briefings on violence prevention: the evidence), 2009, viewed 18 February 2022, <https://www.who.int/violence_injury_prevention/violence/programmes.pdf>.
[80] Australia's National Research Organisation for Women's Safety. (2020). Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020). Sydney: ANROWS, p. 2.
[81] Australian Institute of Health and Welfare, 'Feature Article 3.1: The role of the family in child wellbeing,' Australian Government, Canberra, 2015 p.2, viewed 14 May 2020, <https://www.aihw.gov.au/getmedia/30d3e529-a599-4b39-a30b-8ac63c6617b2/AW15-3-1-role-of-family-in-child-wellbeing.pdf.aspx>.
[82] United Nations Children's Fund, *General comment no. 13: the right of the child to freedom from all forms of violence*, Committee on the Rights of the Child, Geneva, 2011, p. 2.
[83] United Nations Human Rights Council, *Report of the Special Rapporteur on the sale of children, child prostitution and child pornography,* United Nations General Assembly, New York, 23 December 2013, A/25/48, para. 32.
[84] United Nations, *Article 16, United Nations Universal Declaration of Human Rights*, 1948, New York.
[85] United Nations High Commissioner for Refugees, 'Summary Conclusions: family unity,' 2001, Geneva, p. 604, viewed 12 March 2020, < https://www.unhcr.org/419dbfaf4.pdf>.
[86] Council of Australian Governments, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020*, 2009, Commonwealth of Australia, Canberra, p. 12.

In Western Australia, the role of the family is ingrained in the principal legislation governing the care and protection of children, the *Children and Community Services Act 2004,* which identifies 'the principle that the parents, family and community of a child have the primary role in safeguarding and promoting the child's wellbeing' must be observed in the administration of the Act.[87]

5.11.2 Families with multiple, chronic and inter-related problems can have difficulties in meeting children's needs and keeping children safe from harm

Not all children reside in a home 'where some or all aspects of their family are positively functioning' and, 'for some children, families may not be able to provide a safe and supportive environment.'[88]

In fact, family and domestic violence, parental drug and/or alcohol misuse and parental mental health problems frequently co-occur and are associated with child abuse and neglect within the home.[89]

However, it is important to understand that these complex problems occur within a wider context of social exclusion, poverty and trauma and do not arise as a result of individual failings, but rather as part of a complex reaction to structural, relational and distributional disadvantage.[90]

5.11.3 Children and adolescents are vulnerable to violence within their families

The research literature identifies that children living in homes characterised by family and domestic violence have previously been considered the '"silent", "forgotten", "unintended", "invisible" and/or "secondary" victims of domestic violence.'[91] Researchers also identified that child protection and family support systems, 'tended to overlook children who have been exposed to domestic violence in the mistaken belief that "children are untouched by the chaos happening around them in the family home" and a belief that the absence of physical harm meant that no real harm had occurred.'[92] Further, ANROWS has identified that 'in the majority of cases, [Child Protection] workers do not properly document the impact of violence and abuse on children … [and] minimise the impact of [family and domestic violence] on children, through the use of language that framed recorded incidents as an issue between parents only.'[93]

Acknowledgement of the breadth of children's experiences in the context of family and domestic violence was also recognised by former National Children's Commissioner Megan Mitchell. In her 2015 Children's Rights Report, Commissioner Mitchell noted that stakeholders repeatedly identified that 'differentiating between witnessing violence, being

[87] *Children and Community Services Act 2004* (WA), s. 9(a).
[88] Australian Institute of Health and Welfare, *Australia's Children*, 2020, Canberra, p. 231.
[89] Bromfield L et al, *Issues for the safety and wellbeing of children in families with multiple and complex problems: the co-occurrence of domestic violence, parental substance misuse, and mental health problems: NCPC Issues 33,* 2010, National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, p.1.
[90] Bromfield L et al, *Issues for the safety and wellbeing of children in families with multiple and complex problems: the co-occurrence of domestic violence, parental substance misuse, and mental health problems: NCPC Issues 33,* 2010, National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, p. 13.
[91] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 1.
[92] Kovacs K and Tomison A, 'An analysis of current Australian program initiatives for children exposed to domestic violence', *Australian Journal of Social Issues,* 2003, 38(4), p. 514.
[93] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 3.

exposed to violence, and/or being directly abused in the context of family and domestic violence is not helpful.'[94]

The need to challenge how the system conceptualises children's experience of family and domestic violence was recently highlighted by Australian investigative journalist Jess Hill, in her award winning investigation into domestic abuse:

> These are the children we refer to as "witnesses" who've been "exposed" to domestic abuse. Such language does gross injustice to their experience. These children are not bystanders. They are victims in their own right, with needs, fears, and loyalties independent of their abused parent. This is a fact recognised in Australian law: exposure to domestic violence is now considered a form of child abuse.[95]

5.11.4 Family and domestic violence often co-occurs with other forms of child abuse and neglect

ANROWS has identified that being in a household where there is violence 'places children at increased risk of maltreatment, including physical sexual and emotional abuse,' with 'co-occurrence of child maltreatment and neglect within families where there is [family and domestic violence] … usually estimated to occur in 30 to 50 percent of cases.'[96]

Research also identifies that the co-occurrence of family and domestic violence with other forms of child maltreatment 'magnifies the detrimental effects of exposure to [family and domestic violence] on children's emotional and behavioural outcomes,' a '"double whammy" effect' that results in these children experiencing 'worse [outcomes] in later life.'[97]

5.11.5 Family and domestic violence incidents involving children and adolescents are often underreported

There is little reliable data on how many children are affected by domestic abuse in Australia. One survey of 5,000 children found that 23 per cent had witnessed physical violence against their mother or stepmother.[98] Fundamentally, some of these limitations stem from family and domestic violence 'incidents themselves being under-reported,' resulting in a lack of data on children's involvement in these incidents.[99]

Research indicates that the presence of children can be a significant barrier to victims seeking help and reporting of family and domestic violence, particularly due to fear of family separation.[100] Child protection services are also often feared as an additional means by which family separation may occur and are not viewed as a potential source of assistance for women experiencing family and domestic violence.[101]

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[94] National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 121-122.
[95] Hill J, *See What You Made Me Do,* 2019, Black Inc, Carlton, p. 166.
[96] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 9.
[97] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 9; and Herrenkohl TI, Sousa C, Tajima EA, Herrenkohl RC & Moylan C A, 'Intersection of child abuse and children's exposure to domestic violence, *Trauma, Violence & Abuse,* 9 (2), p. 90.
[98] Hill J, *See What You Made Me Do, 2019,* Black Inc, Carlton, p. 165.
[99] Richards, K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 2.
[100] National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 123.
[101] Humphreys C, *Issues Paper: domestic violence and child protection, 2007*, Australian Domestic and Family Violence Clearinghouse, p. 9-11.

This particularly affects Aboriginal and/or Torres Strait Islander families, 'given the history of government removal of children,' and the 'current over-representation of Indigenous children in out of home care.'[102]

Children are also 'especially vulnerable to being subjected to unreported violence, as perpetrators of incidents against children and young people are often their parents or a person whom they depend on for care.'[103]

5.11.6 Family and domestic violence can have a devastating impact upon children's lifelong physical and mental health

Research concerning suicide and children affected by family and domestic violence is often included in broader examinations of factors that make individuals more vulnerable to suicidal behaviour, particularly exposure to adverse childhood experiences including physical and sexual abuse.[104]

Research examining mental health, suicide ideation and attempts establishes 'a strong association between exposure to childhood adversity and psychiatric disorders and suicidal behaviour in adulthood,' with some research also identifying 'increasing severity of childhood adversity corresponding with poorer mental health outcomes.'[105] With regard to suicide attempts and ideation specifically, the research literature identifies:

> Dube et al. used a clinic sample …found that 67% of lifetime suicide attempts, 80% of child or adolescent suicide attempts, and 64% of adult suicide attempts were attributable to having experienced 1 or more adverse childhood events…
>
> A striking finding from our study was that the highest attributable fraction corresponded with any childhood adversity and suicide attempts. More specifically, the results indicated that if childhood physical abuse, childhood sexual abuse, and having witnessed domestic violence did not occur, the prevalence of suicide attempts among women and men in the general population would have been reduced by approximately 50% and 33% respectively.[106]

5.11.7 Australian researchers have identified a link between family and domestic violence and self-harm and suicide by children

Family and domestic violence was the subject of significant work by former Australian Children's Commissioner Megan Mitchell, who examined the impact of family and domestic violence on Australian children:

[102] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 2.
[103] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, Victorian Government, Melbourne, p. 40.
[104] Fuller-Thomson E, Baird SL, Dhrodia R et al, 'The association between adverse childhood experiences (ACEs) and suicide attempts in a population based study,' *Child: care, health and development*, 2016, 42(5), p. 725 and Commission for Children and Young People (Victoria), *Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 8.
[105] Afifi T, Enns M, Cox B et al, 'Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences,' *American Journal of Public Health*, 2008, 98(5), p. 946-952, viewed 4 June 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374808/>.
[106] Afifi T, Enns M, Cox B et al, 'Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences,' *American Journal of Public Health*, 2008, 98(5), p. 946-952, viewed 4 June 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374808/>.

> Family conflict and domestic violence is consistently raised as a precipitating factor for self-harm and suicide among children… adverse family experiences, including domestic violence is now seen as one of the key distal risk factors that may predispose a child or young person to suicidal behaviours.[107]

In 2019, the Victorian Commission for Children and Young People tabled *Lost, not forgotten,* an inquiry into children who died by suicide and were known to child protection authorities. *Lost, not forgotten* examined the lives and stories of 35 children who died by suicide between 2007 and 2019 and identified that 'the 35 children presented with multiple, often chronic, risk indicators that brought them into recurring contact with different systems.'[108]

5.12 Aboriginal perspectives on family violence

Aboriginal and Torres Strait Islander peoples have traditionally recognised health and wellbeing as a holistic concept, derived from their law and culture.[109]

Prior to the arrival of European settlers, Aboriginal laws and culture (although unique to each community) shared a number of features that promoted collective safety and wellbeing through the strength of connections to culture, family and kin, country, law, and spirituality.[110]

The research literature recognises 'that holistic social and emotional wellbeing approaches which nurture healthy connections to family, community, country, body, spirituality, mind, emotions, and culture, are a great source of Indigenous wellbeing and resilience'.[111] Further, building on Aboriginal and Torres Strait Islander people's holistic view of health, the 'spiritual and emotional wellbeing of families' is seen as the foundation for building and maintaining healthy communities.[112]

5.12.1 Family violence is not part of Aboriginal and Torres Strait Islander cultures

Professor Michael Dodson AM, a prominent advocate on issues affecting Australian Aboriginal and Torres Strait Islander people, has stated:

> We have no cultural traditions based on humiliation, degradation and violation.
>
> Let me make this point abundantly clear.
>
> Most of the violence, if not all, that Aboriginal communities are experiencing today are not part of Aboriginal tradition or culture.[113]

[107] Australia's Children's Commissioner Megan Mitchell, Speech at the 13th Australasian Injury Prevention Network Conference, 13 November 2017, viewed 4 June 2020 <https://humanrights.gov.au/about/news/speeches/13th-australasian-injury-prevention-network-conference>.
[108] Commission for Children and Young People (Victoria), *Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 14.
[109] Swan P and Raphael B, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy*, 1995, p. 19.
[110] Parker R and Milroy H, 'Aboriginal and Torres Strait Islander Mental Health: An Overview', in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (2nd ed), 2014, Telethon Kids Institute for Child Health Research and Commonwealth of Australia, p. 25-38.
[111] Dudgeon P, 'Aboriginal and Torres Strait Islander women and mental health', *InPsych*, February 2017, 39(1), viewed 21 March 2022, <https://psychology.org.au/inpsych/2017/february/dudgeon>.
[112] Blagg H, Hovane V, Tulich T et al, 'Law, Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 9-10.
[113] Dodson M, 'Violence Dysfunction Aboriginality,' 11 June 2003, National Press Club, Canberra, p. 2.

Aboriginal women speaking to researchers highlighted their view that 'they have always had gender equality, evidenced by the fact that they have possessed their own laws and dreaming, patterns of governance, and roles in relationships to the Earth and to the community.'[114]

5.12.2 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

The voices of Aboriginal and Torres Strait peoples mirror 'views in the literature that Law and Culture were vital forces in their lives.'[115] As noted by ANROWS, Aboriginal and Torres Strait Islander peoples have long called for cultural responses to family violence to be funded in order to address the ongoing unmet need for healing and prevention 'that covers the whole spectrum of violence on communities':

It is important to acknowledge that 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 such as night patrols. The work of organisations such as the Marninwarntikura Fitzroy Women's Resource Centre, The Men's Outreach Service (MOS) in Broome, the Yiriman Project, and the ongoing advocacy, care and leadership provided by Aboriginal women each day in Western Australia.

5.12.3 Aboriginal family violence in context

While most Aboriginal and Torres Strait Islander people 'do not experience physical or threatened harm', numerous reports, inquiries, journal articles and published statistics have established that Aboriginal women and children are vulnerable to experiencing violence at vastly disproportionate rates.[116]

As noted in the Australian Human Rights Commission Report *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future*, the overrepresentation of Aboriginal and Torres Strait Islander peoples in official statistics is 'indicative of the entrenched social, economic and cultural disadvantage that we face':[117] More particularly, as stated by Australia's National Research Organisation for Women's Safety (ANROWS), 'high rates of family violence cannot be uncoupled from the history of colonial settlement and the multiple traumas resulting from dispossession.'[118]

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[114] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 36.
[115] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 10.
[116] Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework - Measures: 2.10 Community Safety*, 2020, viewed 21 March 2022, <https://www.indigenoushpf.gov.au/measures/2-10-community-safety>; Australian Department of Social Services, *Fourth Action Plan – National Plan to Reduce Violence against Women and their Children 2010-2022*, 2019; Bartels L, *Emerging issues in domestic/family violence research*: *Research in practice no. 10*, 2010, Australian Institute of Criminology; Closing the Gap Clearinghouse, *The role of community patrols in improving safety in Indigenous communities*, 2006; Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities*, 2006; 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*, 2002, Department of Premier and Cabinet, Western Australia.
[117] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney, p. 42.
[118] Blagg H, Williams E, Cummings E et al, *Innovative models in addressing violence against Indigenous women: Final report (ANROWS Horizons, 01/2018)*, 2018, ANROWS, p. 64.

Identifying and understanding the impact of violence against Aboriginal women and children in Western Australia requires recognition of the historical, cultural, spiritual, social and environmental issues against which this violence has developed.[119] As noted 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.'[120]

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 multiple government inquiries and reports.[121]

Colonisation is widely regarded as an ongoing process that continues to impact the social and emotional wellbeing of Aboriginal and Torres Strait Islander people today, as highlighted by suicide researchers Ernest Hunter and Helen Milroy, as survival

> …in the face of trauma across generations, including the forcible removal of children and repeated violations of self and family, demanded that feelings be repressed or dissociated, that the realities of exclusion be denied or distorted (living "as if" one was accepted as part of the wider Australian society), or simply finding the strength to endure with the hope that future generations would be spared the pain of those in the past and present.[122]

While noting that the real extent of family violence 'and the impact of family violence on women and child victims is unknown because there are many barriers to reporting family violence,' population survey data indicates that family violence occurs at higher rates for Aboriginal and/or Torres Strait Islander Australians than for non-Indigenous Australians.'[123]

The research literature also highlights that Aboriginal and/or Torres Strait Islander women, particularly younger women, are more vulnerable to family violence, with women aged 25-34 years and 34-44 years 'most likely to have experienced family and domestic violence.'[124]

[119] Blagg H, Hovane V, Tulich T et al, 'Law Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 5-6.
[120] Healing Foundation, *Our Healing Our Way: Leading and shaping our future – National Youth Healing Forum Report*, 2017, p. 4.
[121] AIHW, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015,* 2015,; AIHW, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018, in brief*, 2018; 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*, 2012; Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, 2016; 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*, 2016, Legislative Assembly, Parliament of Western Australia; 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*, 2017, Australian Government; Holland C, *Close the Gap 2018: A ten-year review: the Closing the Gap Strategy and Recommendations for Reset*, 2018.
[122] Hunter E and Milroy H, 'Aboriginal and Torres Strait Islander Suicide in Context', *Archives of Suicide Research,* 2006, 10:2, 141-157, p. 147-148.
[123] Dudgeon P, Blustein S, Bray A et al, *Connection between family, kinship and social and emotional wellbeing*, 2021, Indigenous Mental Health and Suicide Prevention Clearinghouse, AIHW, p. vi; Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia*, 2018, AIHW, Canberra, p. xi.
[124] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Women's Experiences of Family and Domestic Violence*, 2019, ABS, Canberra.

The research literature further highlights the ongoing effects on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples arising from the 'intergenerational effects of Australia's past policies of forced removal of WA Aboriginal children from their natural families on rates of family breakdown, mental health problems and suicidal behaviour among families impacted by these policies.'[125]

It is thought that social exclusion and disconnection from protective cultural factors including 'social contact/community support', 'family and friends', 'removal from family' and the 'influence of Elders' disrupt cultural continuity and young people's ability to 'have a sense of their past and their cultures … [and] conceive of themselves as having a future (as bearers of that culture).'[126]

5.13 This investigation likely under-represents the relationship between family and domestic violence and suicide

Those examining the relationship between family and domestic violence and suicide highlight key challenges faced in undertaking this research, including gaps in data, changing data, the time taken to investigate and understand the circumstances of death and prior historical factors such as family and domestic violence, delays in the completion of coronial findings and determination of a cause of death, and delays in publicly reporting data or otherwise applying for and obtaining access to data.[127] One significant issue in undertaking this research is that data collected concerning family and domestic violence, and other key information about individuals who died by suicide, is retrospective:

A primary challenge is that in a completed suicide the person best positioned to report on causal or other factors in relation to that suicide is deceased. In the absence of a suicide note, or in the absence of relevant service contacts, it can be extremely difficult to ascertain what factors influenced the individuals' decision to end their life, or indeed what factors might have been decisive in that decision. This makes it difficult to conduct effective research examining causal factors and makes it difficult for researchers to draw firm conclusions around other aspects of the completed suicide.[128]

Due to the underreporting of family and domestic violence and the limitations of available information contained in the records of State government departments and authorities, this investigation also likely under-represents the extent of family and domestic violence among those who died by suicide.

[125] Silburn S, Zubrick SR, Lawrence DM et al, 'The Intergenerational Effects of Forced Separation on the Social and Emotional Wellbeing of Aboriginal Children and Young People', *Family matters,* 2006, *75*, p. 10-17.
[126] Dudgeon P, Calma T and Holland C, 'The context and causes of the suicide of Indigenous people in Australia', *The Journal of Indigenous Wellbeing: Te Mauri*, 2017, 2(2), p. 5-15.
[127] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017,* 2017, New South Wales Government, Sydney, p. 139.
[128] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017,* 2017, New South Wales Government, Sydney, 2017, p. 139.

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6 Volume 3: Contact between victims of family and domestic violence who died by suicide and State government departments and authorities

6.1 Introduction

Coronial inquests and other forms of death reviews, including the Office's own child death reviews and family and domestic violence fatality (homicide) reviews, have frequently identified that women and children experiencing family and domestic violence prior to their death have often had repeated contact with State government departments and authorities.[129]

Australia has a number of obligations relevant to family and domestic violence under three international human rights treaties, namely:

- the *International Covenant on Civil and Political Rights*;
- the *Convention on the Elimination of All Forms of Discrimination Against Women*; and
- the *Convention on the Rights of Persons with Disabilities*.

As noted by the Australian Human Rights Commission (**AHRC**):

> These cascading obligations include the obligation to protect and promote; the right to life and the right to be free from gender-based violence. Both of these rights are underpinned by obligations to prevent death and prevent violence against women and children. This in turn imposes an obligation to act with due diligence to prevent, investigate, punish and provide remedies for acts of violence regardless of whether these are committed by private or State actors. The obligation to act with due diligence includes various elements, such as the duty to; investigate incidents of violence against women, collect data and to provide appropriate training to relevant personnel.[130]

Accordingly, as recommended by the AHRC, this report seeks to '[examine] the ways in which our systems and services performed when they were most challenged … [and investigate] the history of service engagement by the deceased'.[131]

Improving our understanding of contact between State government departments and authorities and the women and children with experiences of family and domestic violence prior to their death by suicide is vitally important to preventing similar deaths occurring in the future, as each contact 'provides an opportunity to recognise and respond'.[132]

In other Australian jurisdictions, family and domestic violence related suicides account for the greatest number of family and domestic violence fatalities and have been shown to have 'higher levels of service contact'.[133]

In Western Australia there is currently no ongoing review or public reporting of family and domestic violence related suicides outside of the child death reviews and own motion

[129] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017* (**NSW 2015-2017 Report**), New South Wales Government, Sydney, 2017; *Child RM* [2020] WACOR 14; Domestic and Family Violence Death Review and Advisory Board, *Domestic and Family Violence Death Review and Advisory Board 2019-2020 Annual Report* (**Qld FVDR Report**), Queensland Government, Brisbane, 2021.
[130] Australian Human Rights Commission, *A National System for Domestic and Family Violence Death Review*– December 2016 p 15.
[131] AHRC, *A National System for Domestic and Family Violence Death Review*, December 2016 p. 7.
[132] Qld FVDR Report 2020-21, p. 12.
[133] Qld FVDR Report 2020-21, p. 55, NSW 2015-2017 Report.

investigations conducted by the Office. Statistics developed and captured by the State Coroner are collected on a regular basis for uploading into the National Coronial Information System (NCIS), however data is only accessible to 'coroners, court staff, forensic pathologists, other medical, scientific or legal professionals tasked with assisting a coroner, and … police whose role involves the investigation of death … subject to approval by the State or Chief Coroner of the requesting jurisdiction'.[134]

6.1.1 The availability of information relating to deaths by suicide is often subject to a delay or 'lag' arising from the different administrative processes for reporting, registering and investigating these deaths

In reporting on suicide deaths, Australian researchers and authorities highlight a number of factors which have a significant impact upon the availability and reporting of data about the number of people who die by suicide. In this context, the Australian Bureau of Statistics notes that 'Lags between when deaths occur and when they are registered can influence the count of deaths, while the flow of information between Coroners courts, Registries, the National Coronial Information System and the ABS can influence what information is available to specify a particular cause of death.'[135] Similarly, the Australian Institute of Health and Welfare (AIHW) identifies that it 'can take a number of years for the coronial process to determine if suicide was the cause of death in a particular case.'[136]

In the context of these identified factors, the Office identified that 2017 was the most recent year for which there was complete data available concerning individuals who died by suicide in Western Australia. Accordingly, the Office used 1 January 2017 to 31 December 2017 as the investigation period.

Since 2017, the most recent ABS statistics regarding Australian deaths by suicide are for the years 2011-2020. In Western Australia, the number of suicide deaths has remained relatively stable between 2017 and 2020, at between 381 and 418 deaths each year.[137] Further, WA Police data shows there has been a significant rise in reported incidents of family and domestic violence in Western Australia between 2017 and 2021, with 'Reports of family violence-related assault and threatening behaviour … 19.3 percent above the 5-year average.'[138]

In 2020-21, WA Police also identified that 'there was a 10.9 percent increase in family violence-related offences against the person compared with 2019-20.'[139]

[134] National Coronial Information System, 'Data access', viewed 21 April 2022 <https://www.ncis.org.au/data-access/request-for-death-investigator-access/>.
[135] Australian Bureau of Statistics, *Causes of Death, Australia,* 2021, ABS, Canberra.
[136] AIHW, *Suicide and self-harm monitoring: The use of mental health services, psychological distress, loneliness, suicide, ambulance attendances and COVID-19*, 2021, viewed 7 January 2022 <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/covid-19>; Dudgeon P and Luxford Y, *Real Time Suicide Data: A Discussion Paper*, 2017, ATSISPEP, p. 8; National Mental Health Commission, 'National Suicide and Self-Harm Monitoring System,' Australian Government, Canberra, 2022, viewed 7 January 2022 <https://www.mentalhealthcommission.gov.au/national-suicide-prevention-office/National-Suicide-and-Self-Harm-Monitoring-System>.
[137] Australian Bureau of Statistics, *Causes of Death, Australia*, 2021, ABS, Canberra.
[138] WA Police, *Western Australia Police Force 2021 Annual Report*, WA Police, 2021, Perth, p. 38.
[139] WA Police, *Western Australia Police Force 2021 Annual Report*, WA Police, 2021, Perth, p. 195.

6.1.2 The Office obtained information and data from a range of State government departments and authorities in relation to the investigation

This investigation obtained information and data about the 410 individuals who died by suicide from a select range of State government departments and authorities, including:

- the Department of Communities;
- the Department of Health;
- the Department of Justice;
- WA Police; and
- Western Australian Courts and specialist tribunals, including the Magistrates Court, the District Court, the Supreme Court, the Children's Court, the Coroner's Court and the Office of Criminal Injuries Compensation.

6.1.3 The Office identified that 410 individuals died by suicide between 1 January 2017 and 31 December 2017

The Office reviewed all of the records, data and information obtained from State government departments and authorities during the course of this investigation relating to the 410 people who died by suicide in Western Australia from 1 January 2017 to 31 December 2017.

The Office provisionally coded information about each person's circumstances of death and contact with State government departments and authorities, including whether family and domestic violence occurred prior to death.

The Office then cross-checked the information from each agency and, where relevant, this review also included information obtained by the Office during child death reviews and family and domestic violence fatality reviews. Finally, for each of the 124 people identifying as women and children that died by suicide, the Office settled its provisional coding on whether they were victims of family and domestic violence known to State government department and authorities based on the totality of the information received, as shown in Figure 2.

The Office's review of these records identified that 68 women and children who died by suicide had been identified as a victim of family and domestic violence by State government departments and authorities prior to their death. Throughout this report, we refer to these victims of family and domestic violence who died by suicide as **the 68 women and children.**

6.2 The 68 women and children who were identified victims of family and domestic violence in WA Police, courts and tribunals, WA Health, child protection and corrective services records and died by suicide

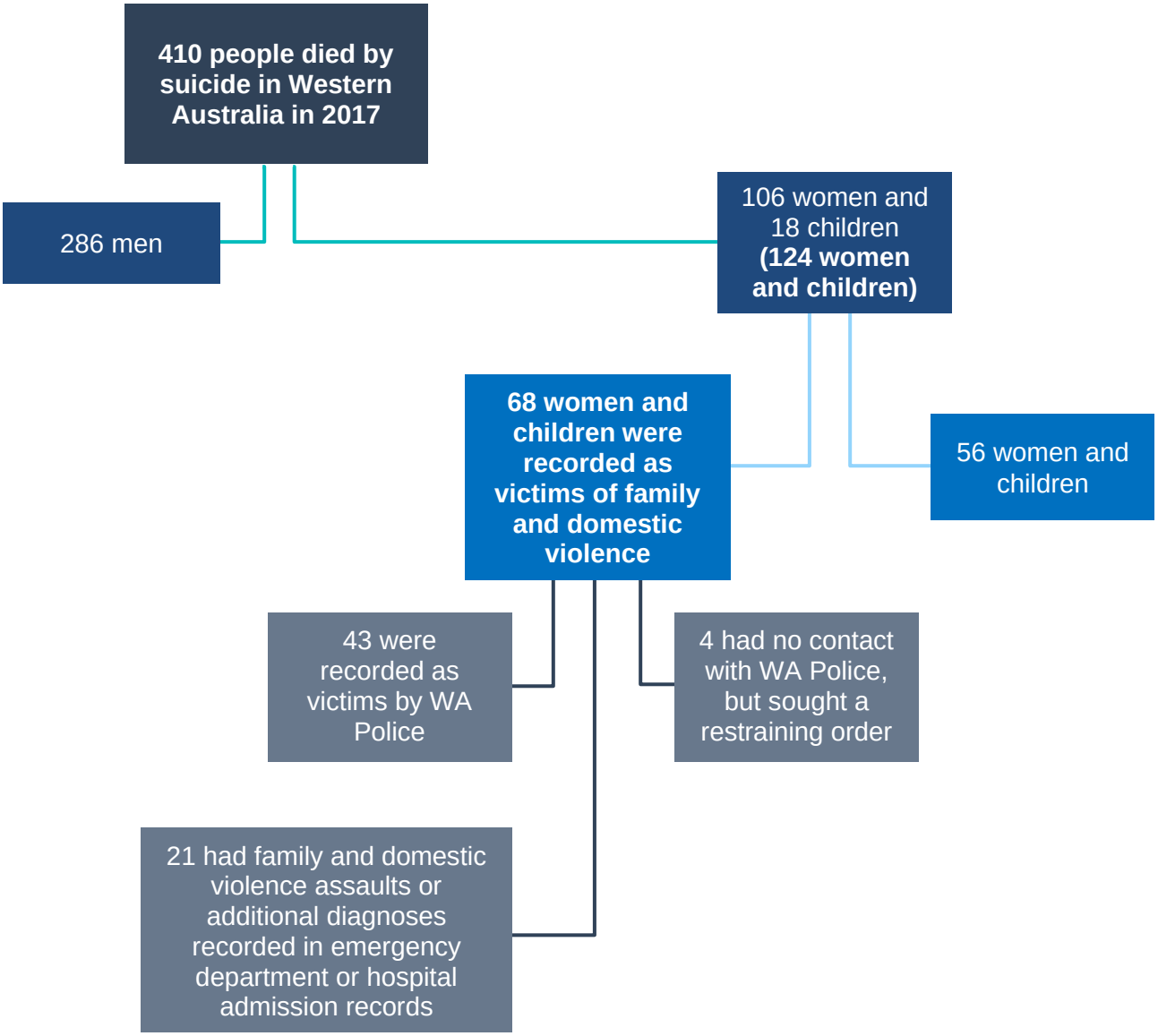
The Office identified 68 women and children as being victims of family and domestic violence prior to their suicide.

Of the 68 women and children identified by the Office as being victims of family and domestic violence prior to their suicide, there were:

- 59 women aged 18 or over at the time of their death, 9 of whom were Aboriginal and/or Torres Strait Islander;
- 9 children aged under 18 at the time of their death, 3 of whom were Aboriginal and/or Torres Strait Islander;
- 48 women aged 26 or older at the time of their death, 7 of whom were Aboriginal and/or Torres Strait Islander; and
- 11 young women aged 25 or under at the time of their death, 2 of whom were Aboriginal and/or Torres Strait Islander.

A summary of the demographic characteristics of the 68 women and children is provided in Table 1.

Figure 2: 68 of the 124 women and children who died by suicide were identified by State government departments and authorities as victims of family and domestic violence



Source: Ombudsman Western Australia

Table 1: Demographic characteristics of the 68 women and children

Age	
10 to 14 years	2
15 to 19 years	8
20 to 24 years	5
25 to 29 years	7
30 to 34 years	7
35 to 39 years	5
40 to 44 years	11
45 to 49 years	8
50 to 54 years	5
55 to 59 years	3
60 to 64 years	3
65 to 69 years	2
70 to 74 years	1
85 plus years	1
Gender	
Female	62
Male	6
Aboriginality	
Aboriginal and/or Torres Strait Islander	12
Non-ATSI	56
Remoteness of Residence	
Inner Regional	5
Major Cities	52
Outer Regional	4
Remote	3
Very Remote	4
SEIFA-IRSD decile rank (within WA)	
1	15
2	4
3	4
4	10
5	2
6	7
7	2
8	6
9	10
10	6
No Fixed Permanent Address	2

Source: Ombudsman Western Australia

6.3 Overview of contact between the 68 women and children and State government departments and authorities

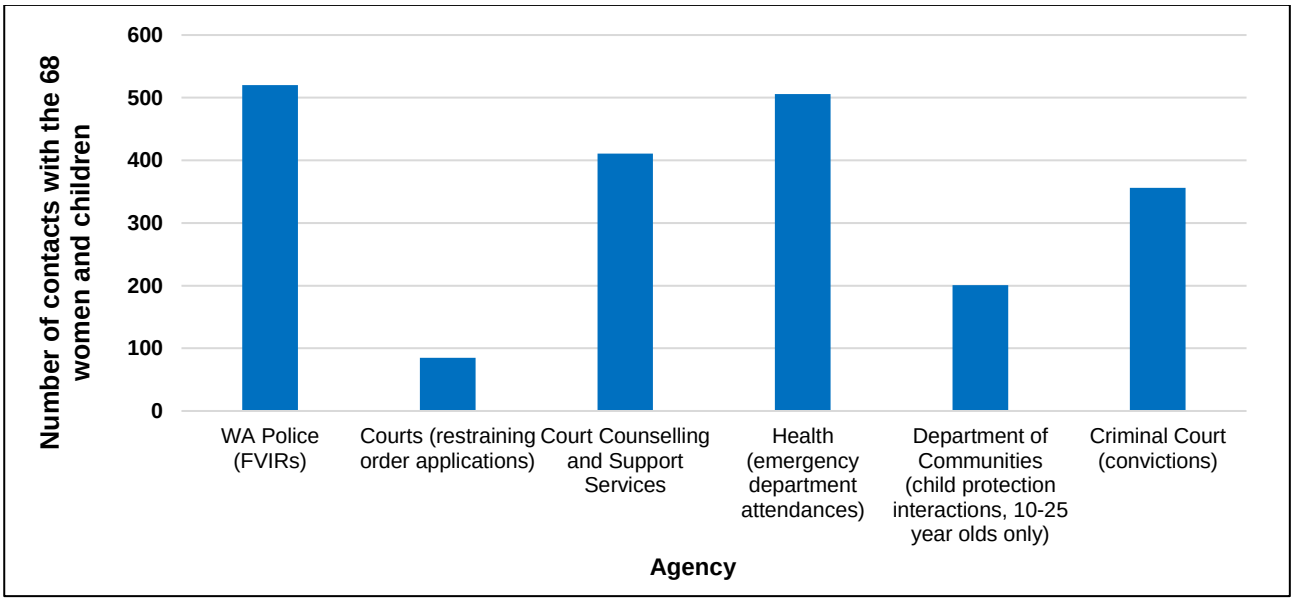
The data in this report relating to the contact between State government departments and authorities is limited to data provided by the WA Police, the Department of Justice, the Department of Health, Health Service Providers and the Department of Communities.

Although this data captures many of experiences of the women and children who were victims of family and domestic violence in dealing with the service system in Western Australia prior to their death by suicide, it is acknowledged that:

- further analysis is required to get a complete picture of longer-term trends and experiences with government funded services and contact where family and domestic violence was not a presenting issue;
- this data does not capture the interaction between services and the women and children who experienced family and domestic violence that was unreported prior to their suicide, including those who may have spoken about their experiences with others such as family and friends;
- contact between the women and children who died by suicide and other agencies and non-government organisations is not captured; and
- the data does not always clearly distinguish between contact where family and domestic violence is the presenting issue or an underlying issue, and where another issue is the primary reason for contact.

The contact between State government departments and authorities documented in this Volume ranges from one-off contact with a single agency to a high number of repeated contacts across multiple agencies, as shown in Figure 3:

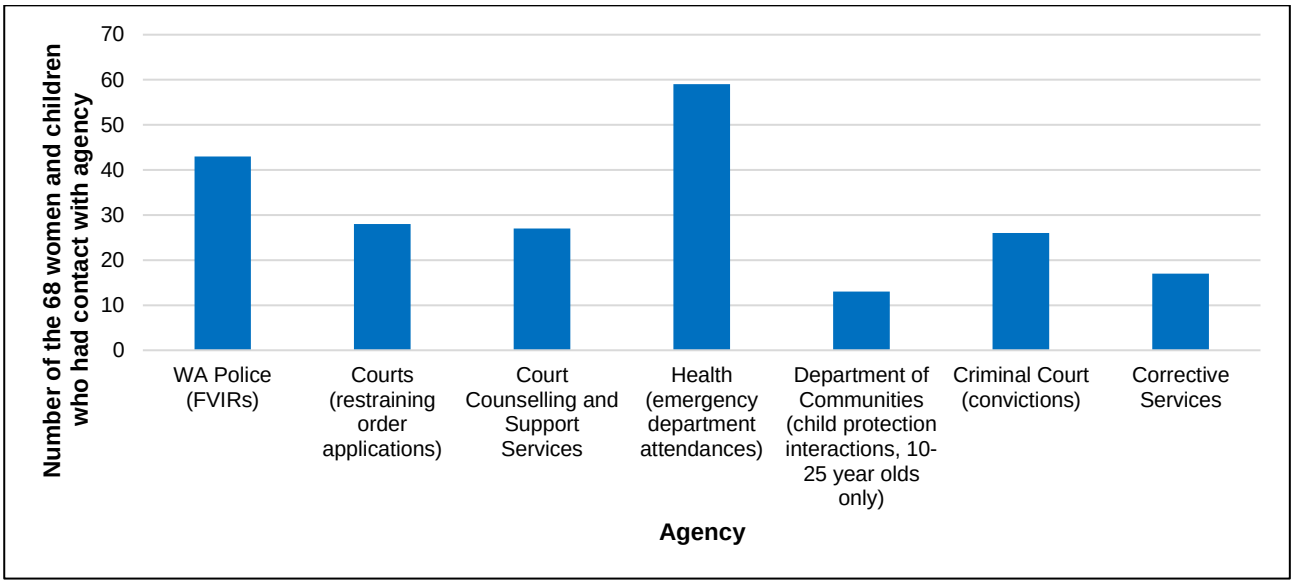
Figure 3: Contact between State government departments and authorities for the 68 women and children



Source: Ombudsman Western Australia

As shown in Figure 4, most of the 68 women and children had contact with the WA Police and emergency departments.

Figure 4: Number of the 68 women and children who had contact with State government departments and authorities, by agency



Source: Ombudsman Western Australia

6.4 Contact between the 68 women and children and WA Police

When responding to family and domestic violence, WA Police record what a responding police officer has seen and been told in a family violence incident report (**FVIR**).

The Office obtained data from WA Police relating to FVIRs in which the 68 women and children who died by suicide were named as a victim or person of interest. The earliest recorded FVIRs relating to those who died by suicide took place in 2003, with WA Police informing the Office that this was due to changes in their information recording practices between September 2002 and December 2004, as follows:

> On 16 September 2002 the Incident Management System (IMS) replaced the Offence Information System (OIS) through the Delta Communications and Technology Program, with the two systems running side by side during the implementation period. By 2004, IMS was available across the agency with all OIS data archived in December 2004.[140]

Accordingly, the data regarding contact which follows is based upon the available data from WA Police spanning 14 years of family and domestic violence incident reports (**FVIRs**) from 2003 until the victims' deaths in 2017.

The Office's analysis of the 68 women and children's contact with WA Police identified that:

- despite most family and domestic violence going unreported to government services, 43 of the 68 women and children had family and domestic violence related contact with WA Police between the introduction of FVIRs in 2003 and their deaths in 2017

[140] Western Australia Police Force, electronic communication, 27 November 2021.

(66 per cent). This is consistent with the research literature identifying experiences of family and domestic violence as a significant psycho-social risk factor for suicide.[141]

- WA Police recorded a total of 520 FVIRs relating to the 43 women and children named in a FVIR by WA Police on one or more occasions prior to their death. The number of FVIRs relating to each woman and child ranged from one to 54, with an average of 12 FVIRs per person and a median of 4.
- Thirty-six of the women and children who died by suicide (84 per cent) had more than one occasion of family and domestic violence related contact with WA Police. Of these 36 women and children with multiple recorded occasions of family and domestic violence related contact with WA Police, 16 had more than 10 contacts (44 per cent).
- Forty-one of the 43 women and children known to have had family and domestic violence related contact with WA Police were identified as a victim of this violence in an FVIR. Of the 43 women and children who had family and domestic violence related contact with WA Police prior to their death, 32 (63 per cent) were identified as both a victim and as a person of interest or offender in FVIRs.
- Twenty-five of the 43 women and children had been named in a FVIR within 12 months of their death (58 per cent).

6.4.1 Twelve women among the 43 women and children known to have had family and domestic violence related contact with WA Police were also recorded as a suspected offender in FVIRs

Across Australia, the problem of misidentification of women as perpetrators of family and domestic violence is shown in the over-representation of women named as respondents in Restraining Order and equivalent legal proceedings (comprising between one fifth and one quarter of these applications), as compared to reliable data on experiences of family and domestic violence.[142]

Women who do not present to Police and other support services in the submissive, passive and cooperative ways depicted in popular culture, including women who use violence in self-defence and those who turn to alcohol or substances in response to the abuse, can be misidentified as suspected perpetrators of abuse, particularly when there are 'mutual allegations of violence.'[143]

Accordingly, our analysis that found twelve women were recorded as both victims and suspected perpetrators of family and domestic violence is not unexpected and is consistent with the findings of previous Australian research.[144]

Throughout this investigation, the Office has sought to use as many sources of information possible in its assessment of women and children as victims of family and domestic violence.

[141] Dillon et al, 'Mental and Physical Health and Intimate Partner Violence Against Women: A review of the literature' (2013) International Journal of Family Medicine 5; Golding, 'Intimate partner violence as a risk factor for mental disorders: A meta-analysis' (1999) 14 Journal of Family Violence 99; Lipsky et al, 'Is there a relationship between victim and partner alcohol use during an intimate partner violence event?' (2005) 66 Journal of Studies on Alcoholism 407; Taft, 'Promoting women's mental health: The challenges of intimate/domestic violence against women' (2003) 8 Australian Domestic Violence Clearinghouse Issues Paper; Devries et al, 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies' (2013) 10(5) PLoS Medicine; Devries et al, 'Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women' (2011) 73(1) Social Science & Medicine 79; Garcia-Moreno et al, 'Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence' (2006) 368(9543) Lancet 1260; MacIsaac et al, 'The association between exposure to interpersonal violence and suicide among women: a systematic review' (2017) 41(1) Australian and New Zealand Journal of Public Health 61.

[142] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS.

[143] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, p. 9.

[144] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020.

The Office also considered data on police orders issued by WA Police as recorded in FVIRs. A police order is an order made by a police officer under Part 2 Division 3A of the *Restraining Orders Act 1997*. Police orders are temporary orders that can only be made in circumstances where a police officer reasonably believes that:

- 'a person has committed an act of family and domestic violence and is likely again to commit such an act;'[145] or
- 'a child has been exposed to an act of family and domestic violence … and the child is likely again to be exposed to such an act;'[146] or
- 'a person will have committed against him or her an act of family and domestic violence;'[147] or
- 'a child will be exposed to an act of family and domestic violence … and that making a police order is necessary to ensure the safety of a person. [148]

Persons named in a police order are referred as the person:

- **Protected:** that is, 'the person or persons for whose benefit the order is made';[149] and
- **Bound:** that is, 'the person on whose lawful activities and behaviour restraints are imposed by the order'.[150]

The Office's analysis of police orders found that WA Police issued a total of 159 police orders in respect of 30 women and three children of the 43 women and children named as a victim in a FVIR. Thirteen women and one child were both protected and bound by police orders. Of these 119 police orders:

- 50 orders bound the 13 women and one child; and
- 69 orders protected the 13 women and one child.

Research on accurately identifying the 'person most in need of protection' acknowledges that '[w]ithout knowledge of the history of the relationship, use of violence against someone who is perpetrating DFV may be misread, and the law will be inappropriately applied.'[151] ANROWS has recommended that 'clearer guidance and training' and 'changes to policing and investigation models' are needed to assist police in better identifying the person most in need of protection:

> … police need clearer guidance and training to assist them to distinguish between coercive controlling violence (physical and non-physical) and violence used in response to ongoing abuse. Explicit guidance on identifying patterns of coercive control would assist police in identifying the person most in need of protection in ambiguous circumstances, and in determining whether a protection order is necessary or desirable.
>
> The changes to policing and investigation models most widely supported by participants were specialist DFV police units or co-responder models. These models see specialists with expertise in coercive control accompany police at investigations, or otherwise support police assessments. Co-responders were

[145] *Restraining Orders Act 1997* (WA), s. 30A(1)(a)(i); Western Australia, *Parliamentary Debates*, Legislative Assembly, 2 June 2004, p. 3303c-3306a (JA McGinty, Attorney General.).
[146] *Restraining Orders Act 1997* (WA), s. 30A(1)(a)(ii).
[147] *Restraining Orders Act 1997* (WA), s. 30A(1)(b)(i).
[148] *Restraining Orders Act 1997* (WA), s. 30A(1)(b)(ii).
[149] *Restraining Orders Act 1997* (WA), section 30E(2)(a).
[150] *Restraining Orders Act 1997* (WA), section 30E(2)(b).
[151] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020.

> widely seen as potential enablers of good police practice in identifying the aggrieved and respondent, and the appropriate action to be taken. Police participants in particular expressed support for specialist and co-responder models as strategies to improve policing responses. … There was widespread recognition that this would require significant resourcing. However, there may be other ways to achieve some of the benefits of a co-responder model. Police in this research suggested, for example, consultation with a specialist unit to support investigation and decision-making on whether an application is necessary or desirable.[152]

Recommendation 1 That the Western Australia Police Force implement the recommended policy and practice reform proposed by Australia's National Research Organisation for Women's Safety (**ANROWS**) in its report on *Accurately identifying the "person most in need of protection" in domestic and family violence law*, including the development of guidance on:

- distinguishing between coercive controlling violence (physical and non-physical) and violence used in response to ongoing abuse;
- identifying patterns of coercive control;
- identifying the person most in need of protection in ambiguous circumstances; and
- determining whether a police order is necessary or desirable.

6.5 Use of restraining orders by the 59 women who died by suicide

The Office examined patterns and trends about the use of restraining orders among the 59 women. This information is useful in learning about occasions when women and children affected by family and domestic violence took action to protect themselves from family and domestic violence.

The Office identified that 28 of the 59 women were involved in restraining order proceedings prior to their death (47 per cent). These 28 women were identified in a cumulative total of 85 distinct restraining order applications. The Office also identified that 19 women had been involved in restraining order proceedings on multiple occasions. The Office's analysis shows that one fifth of the 28 women that were involved in restraining order proceedings (six women or 21 per cent) were involved in proceedings relating to five or more separate restraining order applications.

Of the 28 women that were named in a restraining order, 24 were named as a protected person (86 per cent). Eighteen of the 28 women for whom a restraining order was made, were named as a protected person in the last restraining order made prior to their suicide (62 per cent). Five of these women (17 per cent) had a restraining order naming them as a protected person made within 2 years of their suicide, which is likely to have been current at the time of their death. Three women were named as the respondent in a restraining order made within 2 years prior to their death.

Of the seven Aboriginal and/or Torres Strait Islander women among the 59 women, the Office identified that each (100 per cent) had been the subject of a restraining order at some time prior to their death. These seven women were named in 12 restraining orders. Each of the seven Aboriginal and/or Torres Strait Islander women were named as a protected person in restraining order proceedings prior to their death (100 per cent). Arising from this analysis,

[152] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, citing Larance LY, Goodmark L, Miller S L, & Dasgupta SD, 'Understanding and addressing women's use of force in intimate relationships: A retrospective,' *Violence Against Women*, 2019, 25(1), 56–80, p. 57.

the Office identified that for the seven Aboriginal and/or Torres Strait Islander women named in a restraining order prior to their death:

- four were protected by multiple restraining orders; and
- three were identified as a respondent in one or more restraining orders.

All of the restraining orders for the seven Aboriginal and/or Torres Strait Islander women had been made more than 2 years prior to their death. Accordingly, none of the seven women were likely to have been protected by a restraining order at the time of their death.

6.6 Contact between court counselling and support services and the 68 women and children prior to their suicide

6.6.1 Twenty-seven of the 68 women and children had contact with court counselling and support services prior to their death (40 per cent) on 411 occasions.

Court counselling and support services are provided to victims of crime. In this context, 'victims of crime' includes those who 'suffer injury or loss as a direct result of an offence or [who] … are a member of the immediate family where an offence results in the death of an individual.'[153]

6.7 Contact between criminal courts and the 59 women who died by suicide

The Office undertook analysis to identify how many of the women and children who died by suicide were charged or convicted of a criminal offence. As identifiable data from the Magistrates Court of WA, the District Court of WA, and the Supreme Court of WA concerned criminal offences relating only to adult matters, the Office undertook this analysis for the 59 women known to have experienced family and domestic violence prior to their suicide, who were aged 18 years or older at the time of their death.

6.7.1 Forty-four per cent of the 59 women were convicted of a criminal offence (26 women)

The Office's key findings about the 26 women convicted of a criminal offence were that:

- the 26 women were convicted on 356 occasions, with the majority of these convictions being recorded in relation to traffic and vehicle regulatory offences, offences against government procedures, government security and government operations and public order offences (236 convictions, 66 per cent of the 356 convictions).
- nine women were convicted of offences relating to acts intended to cause injury (16 convictions) and 11 women were convicted of illicit drug offences (37 convictions).

[153] Government of Western Australia, *Court Counselling and Support Services*, viewed 28 May 2022, <https://www.wa.gov.au/service/community-services/counselling-services/court-counselling-and-support-services>.

- analysis of the convictions by Australian and New Zealand Standard Offence Classification (**ANZSOC**) Group codes identified that the 26 women were most frequently convicted of offences for driving while licence disqualified or suspended (11 women, 48 convictions), breaches of bail (10 women, 32 convictions), breaches of community-based orders (5 women, 29 convictions), theft excluding motor vehicles (12 women, 25 convictions) and motor vehicle registration offences (9 women, 22 convictions).
- consistent with WA Police FVIR data and records, the Office's analysis of the convictions for the 26 women also identified that seven women were convicted of breaching a violence order on 19 occasions. Each of these convictions occurred after a guilty plea by the defendant.
- none of the 26 women known to have experienced family and domestic violence prior to their suicide with criminal convictions were convicted of homicide or sexual assault.
- the 26 women known to have experienced family and domestic violence prior to suicide were rarely convicted of acts intended to cause injury, dangerous or negligent acts endangering persons, and abduction, harassment and other offences against the person. These ANZSOC divisions, cumulatively, accounted for 21 of the 356 convictions recorded against the 26 women known to have experienced family and domestic violence prior to their suicide and convicted of a criminal offence (6 per cent of convictions).
- five of the 27 women charged with a criminal offence prior to their suicide had a criminal charge outstanding at the time of their death (19 per cent).

6.8 Contact between corrective services and the 68 women and children

6.8.1 Sixteen of the 68 women and children had contact with corrective services

The Offices key findings about the 16 women and children who had contact with corrective services were that:

- eight of the 16 women and children who had contact with corrective services were Aboriginal and/or Torres Strait Islander.
- most of the 16 women and children had contact with custodial and community-based corrective services, including:
    - three women and 1 child had contact with Youth Justice Services and/or a juvenile detention facility during their childhood (25 per cent);
    - eleven women had contact with Adult Community Corrections (69 per cent); and
    - nine women had contact with an adult custodial facility (56 per cent).
- six of the 11 women managed by Adult Community Corrections were identified in one or more WA Police family and domestic violence incident reports during their during the period of their management in the community.
- five women known to corrective services died while on an active period of adult community management or during a custodial stay.

The Department of Justice advised the Office that Adult Community Corrections 'contributes to the management of those offenders and defendants who are subject to community supervision in a number of ways as a part of the individuals case management,'[154] noting:

[154] Department of Justice, electronic communication, 10 December 2021.

> ACC utilise the Kessler 10 (K 10) Self Harm Assessment Tool and Stress Management Workbooks for those individuals presenting with mental health issues.
>
> The ACC Handbook provides guidance to ACC Case Managers in the management of individuals presenting with mental health and particularly self-harm issues. This guidance incorporates safety screening, assessing mental health and referral pathways.[155]

In addition to this guidance, the Department of Justice further advised the Office that:

- '[all Community Corrections Officers] are required to complete the Correctional Officer Foundation Program,' which includes 'Gatekeeper – Suicide Awareness' training (two-day training), 'Mental Health First Aid' training (two-day training), and 'Mental Health Matters' (half a day training); and
- 'on every occasion that ACC receives confirmation of the death of an offender/defendant subject to ACC supervision, the ACC Directorate will determine if the circumstances of the death require a review of the deceased's Case Management:'

> This review is undertaken by an ACC Manager who is not connected with the case and with the purpose of ascertaining if the deceased's Case Management was conducted in accordance with ACC policy and practice, plus to identify if there were any missed opportunities.
>
> The outcome of these reviews are used to identify if there are any systemic Case Management issues and provides the opportunity to implement any necessary remedial action whether it be on a local level or for ACC state-wide.[156]

Recommendation 2: The Department of Justice consider the findings of this investigation and continues to identify opportunities for community-based suicide prevention for women known to have been victims of family and domestic violence related crime including those:

- receiving support from court counselling and support services; and
- convicted of criminal offences and being managed in the community by Adult Community Corrections.

[155] Department of Justice, electronic communication, 10 December 2021.
[156] Department of Justice, electronic communication, 13 October 2021.

6.9 Contact with between hospitals and the 68 women and children

The Office obtained all emergency department attendance and hospital admission records for the 410 people who died by suicide in Western Australia, for the period between 1 January 2012 and their death, from the Department of Health's Emergency Department Data Collection and Hospital Morbidity Data Collection.

Excluding emergency department attendances and hospital admissions relating to death, the Office identified that, of the 410 people who died by suicide, 340 (83 per cent) attended a hospital emergency department or were admitted to hospital prior to their death.

These 340 people had a total of 1,550 inpatient separations and 1,797 emergency department attendances between 1 January 2012 and the date of their death.[157]

In analysing and considering the data about hospital contact that follows, it is important to bear in mind that the data presented only records the instances a woman or child sought treatment for any reason. The Office acknowledges that the data within this Chapter does not reflect whether or not there was a missed opportunity to recognise and respond to the dual risks of family and domestic violence and suicidal behaviour for each person. Further, the data presented does not convey instances of good practice and high-quality support work provided by hard-working health professionals often working in traumatic, highly stressed and high workload environments in order to deliver the best possible medical care to Western Australians, that may be identified in the course of our review of identified information.

6.9.1 Hospital admissions for the 68 women and children

Excluding admissions where a person died by suicide, the Office identified that 55 of the 68 women and children known to have experienced family and domestic violence prior to their suicide (81 per cent) had one or more hospital admissions between 1 January 2012 and the date of their death. Further, the Office identified that 49 of the 55 women and children admitted to hospital were admitted on multiple occasions (89 per cent), with only 7 admitted once (13 per cent).

Eleven of the twelve Aboriginal and/or Torres Strait Islander women and children known to have experienced family and domestic violence prior to their suicide, were also admitted to hospital (92 per cent). Ten of these 11 Aboriginal and/or Torres Strait Islander women and children were admitted to hospital on more than one occasion (91 per cent), and only one was admitted on a single occasion (9 per cent).

The Office's key findings about the 55 women and children admitted to hospital were that:

- thirty-three of the 55 women and children who had been admitted to hospital, had been admitted on one or more occasions for mental health issues (60 per cent).
- twenty-four of the 55 women and children who had been admitted to hospital, had been admitted on one or more occasions for intentional self-harm (44 per cent).
- three of the 55 women and children admitted to hospital had a recorded diagnosis of suicidal ideation.

[157] Not included in this analysis were:
- thirty-three emergency department attendances with a disposal code indicating that a person died;
- forty hospital admissions with a method of patient discharge code indicating that a person died during an inpatient stay; and
- six-hundred and forty-one emergency department attendances which had no recorded diagnosis or symptom code.

- seven women and children had diagnoses indicative of family and domestic violence (that is, the ICD-10-AM external cause codes indicating an assault perpetrated by a spouse or family member and the additional diagnosis Z63 codes for relationship problems impacting health status).

6.9.2 Emergency department attendances for the 68 women and children

Excluding attendance where a person died by suicide, the Office identified that 59 of the 68 women and children known to have experienced family and domestic violence prior to their suicide (87 per cent) attended an emergency department on one or more occasions between 1 January 2012 and the date of their death.

Further, the Office identified that most of the 59 women and children who attended an emergency department on multiple occasions, with only nine attending an emergency department on a single occasion (15 per cent).

Ten of the 11 Aboriginal and/or Torres Strait Islander women and children known to have experienced family and domestic violence prior to their suicide, also attended an emergency department (91 per cent). Nine of these 11 Aboriginal and/or Torres Strait Islander women and children attended an emergency department on more than one occasion, and only one was attended an emergency department on a single occasion (10 per cent).

The Office's key findings about the 59 women and children who attended an emergency department were that:

- thirty-five women and children attended an emergency department on one or more occasions for mental health reasons (59 per cent) on 114 occasions.
- twenty-three women and children had multiple recorded emergency department attendances for mental health reasons (40 per cent).
- twenty-four of the 59 women and children that attended an emergency department, attended on one or more occasions for intentional self-harm (41 per cent).
- twenty of the 59 women and children presented to an emergency department for reasons relating to suicidal ideation on 43 occasions (34 per cent).

6.9.3 Proximity of contact with hospitals for the 59 women and children who attended an emergency department and/or were admitted to hospital between 1 January 2012 and their death

The Office analysed the time between the last attendance at an emergency department and/or last hospital admission and death by suicide for each of the 59 women and children known to have had contact with a hospital, and found that:

- thirty-four of the 59 women and children who attended an emergency department between 1 January 2012 and their death in 2017, presented at an emergency department within the 90 days prior to their death.
- twenty of the 55 women and children admitted to hospital between 1 January 2012 and their death in 2017, were discharged from a hospital admission within the 90 days prior to their death.

6.10 Contact between child protection services and 13 children and young women known to the Department of Communities

In 2020, the Ombudsman tabled his major own motion investigation report on *Preventing suicide by children and young people 2020*, which analysed the deaths of 115 children and young people who died by suicide in Western Australia between 1 July 2009 and 30 June 2018.

Arising from this analysis, the Office identified that the majority of the 115 children and young people (70 children and young people, 61 per cent) experienced significant and enduring life difficulties, including alleged child abuse or neglect and family dysfunction. Significantly, among these 70 children and young people (referred to in the report as 'Group 1') 53 had allegedly experienced family and domestic violence prior to their death.[158]

Comprehensive data collection about children's experiences and perceptions of family and domestic violence is crucial in underpinning the development of services intended to assist children affected by family and domestic violence.

Building the evidence base of data on family and domestic violence in Australia has also been identified as a foundation for change under *Australia's National Plan to Reduce Violence against Women and their Children 2010-2022* (**the National Plan**).[159]

The Office undertook in depth analysis to understand the experiences of children and young people known to have experienced family and domestic violence who died by suicide. This investigation analysed the 20 children and young women who died by suicide during the investigation period. The Office's key findings about the 20 children and young women's contact with child protection services were that:

- the Department of Communities received information about the wellbeing of 13 children and young women who died by suicide in 201 interactions;
- all of the 13 children and young women known to the Department of Communities were the subject of multiple referrals;
- four of the 13 children and young women known to the Department of Communities were the subject of a Child Safety Investigation as children;
- two children were in the care of the Chief Executive Officer at the time they died by suicide;
- family and domestic violence was the second most frequently recorded primary issue in the 201 interactions for the 13 children and young women known to the Department of Communities;
- family and domestic violence was the most frequently recorded 'other' issue among the 201 interactions for the 13 children and young women known to the Department of Communities;
- the Department of Communities recorded family and domestic violence as an issue in 66 of the 201 interactions relating to the 13 children and young women, while the Office identified family and domestic violence in 110 of the 201 interactions relating to the 13 children and young people;

[158] Ombudsman Western Australia, *Preventing suicide by children and young people 2020, Volume 1: Ombudsman's Foreword and Executive Summary*, September 2020, p. 25.
[159] Australian Bureau of Statistics, 'Defining the data challenge for family, domestic and sexual violence: Summary 2013,' Canberra, 2013, viewed 15 June 2020 <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4529.0.00.001main+features32013>.

- the Department of Communities recorded the outcome of 'not departmental business' or 'assessed as no further role' in 35 per cent of interactions where the Office identified family and domestic violence;
- of the 110 interactions relating to the 13 children and young women where the Office identified family and domestic violence, the Department of Communities progressed to intake for additional actions on 26 occasions (27 per cent);
- nine of the 13 children and young people known to the Department of Communities were first in contact with the Department as a child between the ages of 0 and 13;
- referrals to the Department of Communities regarding the 13 children and young women occurred most frequently at age one and between the ages of 14 and 17 years;
- family and domestic violence related interactions for the 13 children and young women occurred most frequently between the ages of 10 and 13 years and again between the ages of 14 and 17 years; and
- intake of concerns for the 13 children and young people by the Department of Communities occurred most frequently at ages 1 and 13. Intake of interactions occurred most frequently at age 1 and between the ages of 10 to 13 years.

The Office consulted with the Department of Communities about patterns and trends in how the Department identified and responded to family and domestic violence among the children and young women who died by suicide, and was advised that the Department is 'currently undertaking a review of the practice guidance relating to family and domestic violence practice.'[160]

Recently, the Department of Communities has partnered with the Safe & Together Institute to examine the current systemic family and domestic violence responses in Western Australia. In utilising the Safe & Together Institute's Continuum of Domestic Violence Practice, the Department of Communities has highlighted that the 'Department of Communities' competency in responding to family and domestic violence sits across Domestic Violence Destructive, Domestic Violence Neglectful and Domestic Violence Pre-Competent.'[161]

Accordingly, the Department of Communities has highlighted that:

> Communities is developing a Western Australian FDV-Informed Approach that is family violence, trauma and culturally-informed. The development of this approach sits across Strategy and Partnerships, Aboriginal Outcomes and Community Services.
>
> We have partnered with the Safe and Together Institute to start this work:
>
> 1. An organisational assessment of Communities family and domestic violence policies, systems and practices. This is a process that requires staff to audit / review policies, data systems, governance arrangements etc. to examine current family violence capability. It includes a case reading analysis (same methodology as used in the PATRICIA research project) to support detailed analysis of current responses to family and domestic violence (an initial draft has been received by Communities).

[160] Department of Communities, electronic communication, 29 October 2021.
[161] Department of Communities, 'Family and Domestic Violence-Informed Approach' (PowerPoint presentation), Government of Western Australia, delivered 9 September 2021, Perth, slide 5.

2. Participatory protocol development. Informed by the organisational assessment, Safe and Together Institute will work with Aboriginal staff and Aboriginal stakeholders to develop approaches for working with Aboriginal families.

3. Implementation of the participatory protocol, and other necessary changes identified through the organisational assessment, to embed good family violence practice in our people, policy and systems.[162]

The Department of Communities has highlighted that work on a family and domestic violence informed approach, and the priority of family and domestic violence responses is congruent across agency projects and ongoing work, including:

- Aboriginal Cultural Framework and Cultural Capability.
- Aboriginal family safety strategy.
- Communities family and domestic violence service model.
- Recommissioning the family and domestic violence sector.
- Developing an integrated family and domestic violence response.
- Senior Officer's Group - Reinvigorated across government commitment.[163]

Recommendation 3: The Department of Communities, working together with relevant State government departments and authorities and stakeholders, identify strategies and practices for identifying, recording, and utilising information about children and adolescents' experiences of family and domestic violence. Including, but not limited to:

- the number of children affected by family and domestic violence in Western Australia;
- the nature of how children and adolescents experience family and domestic violence; and
- strategies, principles, and practices for collecting information about children affected by family and domestic violence.

Recommendation 4: That the Department of Communities consider and incorporate the findings of this investigation when undertaking the development and implementation of a 'Western Australian Family and Domestic Violence-Informed Approach,' regarding:

- the recording of family and domestic violence as a 'primary issue' or 'issue' in ASSIST;
- use of the outcomes 'Not departmental business' or 'Assessed as no further role' when family and domestic violence is identified; and
- the intake of interactions relating to family and domestic violence.

[162] Department of Communities, 'Family and Domestic Violence-Informed Approach' (PowerPoint presentation), Government of Western Australia, delivered 9 September 2021, Perth, slide 6.
[163] Department of Communities, 'Family and Domestic Violence-Informed Approach' (PowerPoint presentation), Government of Western Australia, delivered 9 September 2021, Perth, slide 7.

6.11 Opportunities to improve outreach and engagement with young people and their families

6.11.1 The research literature highlights that interventions with adolescents often focus on addressing immediate risks and challenging behaviour, instead of the underlying causes

Recent research in the UK has examined issues that arise in interactions with adolescents, including work by the UK's National Society for the Prevention of Cruelty to Children (**NSPCC**) which has published learnings from 15 case reviews that were published between 2018 and 2019 featuring children and adolescents aged 13 to 18 years. Teenagers in these case reviews 'faced a complex lived experience and wide range of risk factors [and] became the subject of reviews following: suicide or attempted suicide, physical injuries or death at the hands of another person, child sexual abuse and sexual abuse, neglect, and criminal exploitation.' Arising from these reviews, the NSPCC identified a number of key learnings about the manner in which adolescents were perceived and engaged.

The NSPCC identified that 'practitioners sometimes struggle to work with teenagers who are experiencing complex issues [and that] interventions can focus on tackling challenging behaviour, rather than exploring the underlying causes and risk factors.'

6.11.2 The research literature identifies a need to recognise the vulnerability of young people and not overestimate their maturity or 'resilience'

AIHW notes that 'infants [and] younger children are regarded as the most vulnerable [to being] abused, neglected or otherwise harmed', and more often receive a response from child protection services. [164]

The Office's 2020-2021 Annual Report identifies that children aged 13 to 17 years are also 'over-represented compared to the child population as a whole for both investigable and non-investigable deaths.'[165] Thirty-three per cent (335) of the 1,002 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2021 related to those aged 13 to 17 years, and 35 per cent of these deaths were investigable.[166] 'Of these children, suicide was the most common circumstance of death, accounting for 45% of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide.'[167]

Researchers highlight the need to counter assumptions about the resilience and independence of teenagers, noting that 'it is easy to fail to recognise or minimise the vulnerability of older children.'[168]

In reviewing the involvement of vulnerable adolescents and older children with services, UK researchers identified a tendency for practitioners to adopt an approach that affords maturity to adolescents, rather than centring their status as children.

[164] AIHW, *Family, domestic and sexual violence in Australia: 2018*, 2018, Australian Government, p. 64.
[165] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 63.
[166] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 80.
[167] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 63, 91.
[168] Queensland Department of Child Safety, Youth and Women, *Practice Paper: A framework for practice with 'high risk' young people (12 – 17 years)*, 2008, Queensland Government, p. 1-2.

The NSPCC identified that at times, 'practitioners perceived a young person to be independent and mature. This led them to be quick to act in accordance with the young person's expressed wishes, even when it was not necessarily in the young person's best interests.'[169] This, combined with a focus upon the challenging or risk-taking behaviour of adolescents, 'sometimes causes practitioners to lose sight of the fact that teenagers are children in need of protection.'[170]

Similarly, consultation undertaken by Crest Advisory identified that, rather than meeting the threshold for support (in the cases of criminally-exploited children), there was 'a tendency to view these young people's behaviour, especially in the case of boys, as a sign of criminality, almost a lifestyle choice, rather than evidence of a vulnerable child in need of protection.'[171]

6.11.3 The research literature identifies the need to view older children and adolescents' challenging behaviours and unwillingness to engage with services in the context of the long-term impacts of trauma, violence, abuse and neglect

Researchers have identified that in dealing with adolescents, practitioners 'are not always aware of the long-term impact that abuse and neglect experienced in earlier childhood can have on teenagers' mental health and behaviour.'[172]

The JTAI response report identifies that early childhood or chronic trauma 'will most likely affect a child's mental and emotional well-being and behaviour into adolescence and beyond.'[173] Research also identifies that adolescents' experiences of trauma can influence their engagement with services, eroding trust in adults, the wider environment, and services offered. This is further compounded when support from services 'often focuses on managing immediate risks rather than building trust.'[174]

6.11.4 The Office identified barriers to effective outreach and engagement with older children between the ages of 14 to 17 years from the Department of Communities' interaction notes for the 13 children and young women known to the Department of Communities

The Office's analysis identified that the 13 children and young women known to the Department of Communities most frequently came to the attention of the Department when they were between the ages of 14 and 17 years.

In the context of the research literature, and in understanding that infants and younger children are often regarded as most vulnerable to harm, the Office undertook qualitative analysis to identify insights into the nature of concerns regarding the 13 children and young women, and the attitudes and decision-making processes of professionals responding to these issues.

[169] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 2.
[170] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[171] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.
[172] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 3.
[173] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 6.
[174] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 50.

The Office observed parallels between issues that were identified in the research literature and in the dialogue of interactions concerning the 13 children and young women during periods of contact as adolescents, including:

- **perceptions of challenging behaviour**: the research literature identifies that engagement with adolescents sometimes focuses on tackling behaviours, rather than exploring underlying causes and risk factors;[175]
- **affording maturity to adolescents:** researchers identify a tendency for practitioners to adopt an approach that affords maturity to adolescents, rather than centring their status as children. At times this manifested in adolescent's behaviour being perceived as 'a lifestyle choice,'[176] or young people being 'allowed to make decisions beyond their capacity.'[177] In other instances, 'children's lack of willingness to engage with professionals was seen as a reason to end social work involvement';[178] and
- **the long-term impacts of trauma, violence, abuse and neglect:** the research literature identifies that early childhood or chronic trauma 'will most likely affect a child's mental and emotional well-being and behaviour into adolescence and beyond.'[179] Researchers identify that in working with adolescents, there is a propensity for interventions to 'focus on tackling challenging behaviour, rather than exploring the underlying causes and risk factors.'[180]

Underpinning these issues, researchers have identified that a tendency to view the actions of adolescents as arising from the conscious decisions of mature individuals does not align with the reality that 'anyone aged under 18 is legally a child and should be protected as such.'[181] In Western Australia, the provisions of the *Children and Community Services Act 2004* relate to 'children', as defined in section 3. That is, 'a person who is under 18 years of age.'

Recommendation 5: The Department of Communities, in order to better inform practice and policy, conducts a review and examines current data on:

- the presence of family and domestic violence in duty interactions concerning older children and adolescents;
- intake rates related to duty interactions concerning older children and adolescents, particularly where family and domestic violence is identified;
- policy, practice, and culture in relation to how the Department of Communities responds to older children and adolescents; and

provides the resulting review report to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this Investigation.

[175] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[176] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.
[177] Commission for Children and Young People (Victoria), *Neither seen nor heard: Inquiry into issues of family violence in child deaths*, 2016, Victorian Government, p. 40.
[178] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 24.
[179] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 6.
[180] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[181] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 5.

7 Volume 4: The need for trauma informed responses

7.1 Trauma

The research literature identifies that trauma is 'both the experience of, and a person's response to, an overwhelmingly negative event or series of events'[182] that are emotionally disturbing or life-threatening:[183]

The Blue Knot Foundation, Australia's National Centre of Excellence for Complex Trauma, identifies that trauma 'is a state of high arousal in which severe threat or the perception of severe threat overwhelms a person's capacity to cope. It comprises a range of events, situations and contexts. These include natural disasters, accidents, betrayal in interpersonal relationships, and diverse forms of abuse.'[184]

In defining trauma, researchers differentiate between simple and complex trauma. Simple trauma is the term used for single-incident trauma involving experiences or events 'that are life threatening and/or have the potential to cause serious injury'[185] and are generally unexpected. Simple trauma can include experiences such as being in a car accident, house fire, natural disaster, fighting in a war, or experiencing assault in adulthood.[186]

Where simple trauma is generally the experience of a single, unexpected event, complex trauma is often ongoing and interpersonal, occurring in relationships that are meant to be safe:

> **Complex Trauma** occurs as a result of traumatic stressors that are interpersonal – premeditated, planned and perpetrated by one human being on another. It is particularly damaging if it occurs in childhood. These actions can be both violating and exploitative of another person.[187]

When trauma is transferred across a number of generations, 'it is known as transgenerational trauma' and extends beyond individuals to families and communities.[188] In Australia, transgenerational trauma impacts Aboriginal and Torres Strait Islander people who have experienced trauma because of 'colonisation, including the associated violence and loss of culture and land, as well as subsequent policies such as the forced removal of children. In many Indigenous families and communities, this trauma continues to be passed from generation to generation with devastating effects.'[189]

[182] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.
[183] Centre for Health Care Strategies, 'Understanding the Effects of Trauma on Health,' 2017, p. 1.
[184] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 45.
[185] Thomas L, *What is trauma?*, 2019, Australian Childhood Foundation, Richmond, viewed 11 October 2021 <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[186] Blue Knot Foundation, 'What is Complex Trauma', 2021, viewed 11 October 2021, <https://blueknot.org.au/resources/understanding-trauma-and-abuse/what-is-complex-trauma/> and Thomas L, *What is trauma?*, 2019, Australian Childhood Foundation, Richmond, viewed 11 October 2021 <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[187] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.
[188] Blue Knot Foundation, *Intergenerational Trauma: Fact Sheet*, 2021, p. 1.
[189] Australians Together, 'Intergenerational Trauma,' 2021, viewed 12 November 2021 <https://australianstogether.org.au/discover/the-wound/intergenerational-trauma/>.

The research literature identifies that people impacted by trauma 'characteristically present at a wide range of services. They often have severe and persistent mental health and coexisting substance abuse problems and are frequently the highest users of the inpatient, crisis and residential services.'[190]

> A large percentage of those seeking help across a diversity of health and human service settings have trauma histories severely affecting their mental and physical health and wellbeing. The impacts of trauma characteristically persist long after the trauma has ended. Although exact prevalence estimates vary, there is a broad consensus that many consumers who engage with public, private and community managed mental health and human services are trauma survivors and that their trauma experiences shape their responses to service providers.[191]

Researchers identify that individuals with experiences of trauma 'are found in multiple service sectors.' These include:

- **Mental Health Services:** research has found that 'nine out of 10 people accessing mental health services have experienced trauma at some stage in their life;'[192]
- **Child protection systems:** researchers identify that 'children and families in the child welfare system 'experience high rates of trauma and associated behavioral health problems;'[193]
- **Police:** Experiencing trauma has been linked with increased rates of criminal behaviour;[194]
- **The juvenile and criminal justice system**: 'Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma;'[195]
- **Homelessness:** AIHW identifies that 'half (54%) of [the] children and young people who received homelessness and child protection services [in 2016-17] were [also] experiencing family and domestic violence;'[196] and
- **Alcohol and other drugs treatment programs:** research identifies that over 80 per cent of individuals entering substance use treatment programs 'report having experienced a traumatic event in their lifetime,' and that the 'vast majority have experienced multiple traumas.'[197]

[190] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia*, 2013, p. 4.
[191] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 4.
[192] New South Wales Agency for Clinical Innovation, *Trauma-Informed Care and Practice in Mental Health Services*, 2021, New South Wales Government, viewed 21 October 2021 <https://aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services>.
[193] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 2.
[194] For example, Atkinson, J, *Trauma-informed services and trauma-specific care for Indigenous Australian children: Resource sheet no. 21*, 2013, Closing the Gap Clearinghouse, Australian Institute of Health and Welfare; Randall M and Haskell L, 'Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping', *Dalhousie Law Journal*, 36(2), 2013, p. 516; Ardino V, *Offending Behaviour: The Role of Trauma and PTSD*, 2012.
[195] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 2.
[196] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018,* 2018, p. 65.
[197] Mills K, 'Trauma and substance use,' Presentation at the Western Australian Network of Alcohol & other Drug Agencies WA AOD Conference, March 2018, viewed 21 October 2021 <https://cracksintheice.org.au/pdf/webinar-trauma-substance-use.pdf>.

7.1.1 Trauma survivors display extraordinary strength and resilience, and recovery from trauma is possible

Researchers have identified that 'we know far more' about trauma and post-traumatic symptoms 'than we do about resiliency' arising from family and domestic violence.[198] Increasingly, researchers have found that recognising an individual's strength is vital in responding to trauma:

> … a list of symptoms tells us little about the tremendous strengths and resources battered women draw on to recover from domestic violence. The pain individuals experience from domestic violence should not be minimized. Yet, it does not have to be the centerpiece of one's identity. Standing alongside the entire range of debilitating effects of trauma, most survivors display a stunning capacity for survival and perseverance. Growth and pain, therefore, are not necessarily mutually exclusive, but instead are inextricably linked in recovery from trauma.[199]

Resilience refers to 'the capacity of human beings of any age to survive and thrive in the face of adversity.'[200]

7.1.2 Trauma can have long-term impacts upon individuals

Researchers identify that the long-lasting adverse effects of an event 'are a critical component of trauma,' noting that:

> These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic events and the effects.[201]

As a result of advances in diverse and numerous fields, there is a growing body of evidence showing that experiencing trauma or traumatic events can have significant impacts upon individuals, raising their risk of long-term physical and behavioural health issues.[202]

The Australian Childhood Foundation has also highlighted that, with respect to children experiencing toxic stress:

> Children and young people affected by high impact stress and toxic stress find it difficult to make meaning from their experiences. They have few or no effective internal maps to guide their actions. As a result, they react rather than respond.[203]

[198] Anderson K, Renner L and Danis F, 'Recovery: Resilience and Growth in the Aftermath of Domestic Violence,' *Violence Against Women*, 18(11), 2012, p. 1280.
[199] Anderson K, Renner L and Danis F, 'Recovery: Resilience and Growth in the Aftermath of Domestic Violence,' *Violence Against Women*, 18(11), 2012, p. 1280.
[200] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[201] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 8.
[202] Shonkoff J and Garner A, 'The Lifelong Effects of Early Childhood Adversity and Toxic Stress,' *Pediatrics*, 2012, 129(1), p. e232, viewed 11 October 2021, <http://www.pediatrics.org/cgi/doi/10.1542/peds.2011-2663>; Centre for Health Care Strategies, *Understanding the Effects of Trauma on Health*, 2017, p. 1.
[203] Tucci J, Mitchell J, Lindeman M et al, *Strengthening Community Capacity to End Violence: A Project for NPY Women's Council*, 2017, NPY Women's Council and Australian Childhood Foundation, p. 18.

The research literature suggests that experiencing trauma can result in the development of neurological and psychological symptoms, and '[i]n the absence of treatment, [these] trauma-related difficulties and their effects tend to persist into adolescence and adulthood and become difficult to reverse.'[204] The brain's 'remarkable adaptiveness' and the ability of the nervous system 'to change its activity in response to intrinsic or extrinsic stimuli by reorganizing its structure, functions, or connections' can mean that, 'if the initial trauma is not resolved and the person has not recovered, he/she can be repeatedly "triggered" into survival responses by seemingly minor stressors.'[205]

Coping strategies may assist a person to manage dysregulation and overwhelming stress arising from trauma in the short term. Often though, the long-term effects of trauma prove to be 'pervasive and cannot be compartmentalised.'[206] Accordingly, over time, the coping strategies used by a person who has experienced trauma, may decrease in their effectiveness, and cause trauma-organised 'profound neurobiological adaptations' which may be injurious to their health.'[207]

7.1.3 Adaptations arising from trauma may influence behaviour and lead to difficult or discordant interactions with service systems

Dr Sandra Bloom, former President of the International Society for Traumatic Stress Studies and Chair of the Campaign for Trauma-Informed Policy and Practice in the United States, has highlighted that 'many people who present to social service and health organisations, especially 'high utilisers', will have a trauma history, and this may lead to difficult or discordant interactions.'[208]

Additionally, researchers identify that 'challenging behaviours' can be adaptive responses to trauma.[209] For example, a 'mistrust of authority figures and wariness of professional helpers,' rather than being interpreted as 'hostility, lack of motivation or resistance to services', may be viewed as a normal, 'protective reaction when an individual feels vulnerable.'[210] In this sense, trauma informed approaches serve to 'normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance.'[211]

[204] For example, see: van der Kolk B, *The Body Keeps Score: Brain, mind and body in the healing of trauma*, New York, 2014; Schore A, 'Dysregulation of the Right Brain: A Fundamental Mechanism of Traumatic Attachment and the Psychopathogenesis of Posttraumatic Stress Disorder', *Australian and New Zealand Journal of Psychiatry*, 2002(36), p. 9-30; Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice; Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice, p. 1.
[205] Rosenzweig J, Jivanjee P, Brennan E et al, 'Understanding Neurobiology of Psychological Trauma,' Pathways Research and Training Centre, Portland, 2017, p. 2, viewed 12 October 2021 <https://www.pathwaysrtc.pdx.edu/pdf/projPTTP-neurobiology-tip-sheet.pdf>; Mateos-Aparicio P, and Rodriguez-Moreno A, 'The Impact of Studying Brain Plasticity,' *Frontiers in Cellular Neuroscience*, 2019, viewed 12 October 2021 <https://www.frontiersin.org/articles/10.3389/fncel.2019.00066/full>; Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 11.
[206] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxxi.
[207] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxxi.
[208] Bloom S (2019) and Mautner et al (2013) cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[209] Blue Knot Foundation, 'Foundations for Building Trauma Awareness: Professional Development Training Booklet,' delivered 17 September 2021.
[210] Levenson J, 'Trauma-Informed Social Work Practice,' *Social Work*, 2017, 62(2), p. 105-113, viewed 18 October 2021 <https://doi.org/10.1093/sw/swx001>.
[211] Henderson C, and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 79.

7.1.4 Services can unintentionally re-traumatise individuals

Researchers identify a broad consensus that 'many consumers who engage with public, private and community managed mental health and human services are trauma survivors,' with 'trauma experiences shape[ing] their responses to service providers:'

> People impacted by trauma characteristically present to multiple services over a long period of time and care is often fragmented with inadequate coordination between services, and poor referral pathways and follow-up protocols which results in a `merry go round' of unintegrated care. This risks retraumatisation and compounding problems as a result of unrecognised trauma. Such escalation and entrenchment of symptoms is psychologically, financially and systemically costly. Understanding that trauma underpins the way in which many people present who attend a diversity of service settings necessitates substantially new ways of operating.[212]

How services are provided 'can have important impacts on health and well-being,' particularly for individuals experiencing trauma:

> When serving survivors of trauma and violence, a lack of understanding of the complex and lasting impacts of these experiences may lead to harm and to missed opportunities to provide effective care.[213]

7.2 Trauma informed approaches to service provision

Researchers identify that trauma informed interventions 'occur at two levels: trauma-specific interventions and trauma informed models of care.' [214]

Trauma specific clinical interventions 'refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma.'[215] Trauma specific interventions include diagnostic and treatment services 'designed to treat the actual sequelae of sexual or physical abuse trauma … [such as] grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help make to render painful images more tolerable, and behavioural therapies which teach skills for the modulation of powerful emotions.'[216]

Trauma informed approaches or services 'do not directly treat trauma or the range of symptoms with which its different manifestations are associated,' however, they are 'informed about, and sensitive to, trauma related issues' and incorporate key trauma principles into organisational care.[217]

[212] Bateman K, Henderson C and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, p. 1.
[213] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.
[214] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 4.
[215] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 4.
[216] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15-16, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[217] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, Blue Knot Foundation, NSW, p. 88; Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, p. 9.

> A 'trauma informed' system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services. A 'trauma informed' system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in 'traumatology'.[218]

Researchers identify that the provision of both trauma specific clinical interventions and trauma informed approaches are essential in addressing the consequences of trauma, noting that 'the provision of trauma informed services must also be supported by trauma specific services, which provide specific interventions to address the consequences of trauma.'[219] Similarly, trauma specific services require a trauma informed 'environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services.'[220]

The Office's focus on trauma informed approaches relates to the broader organisational or service system responses that are **trauma informed**, rather than trauma specific clinical interventions. However, growing awareness of trauma and its impacts have led to calls from researchers for the need for both trauma informed and trauma specific services.[221]

The research literature identifies that trauma informed approaches aim to 'normalise symptoms and behaviours that have traditionally been pathologized,' with the approach asking 'what has happened to you?' rather than, 'what is wrong with you?'[222]

The Blue Knot Foundation has identified that trauma-informed services:

- attune to the possibility of trauma in the lives of everyone seeking support
- apply the core principles of safety, trustworthiness, choice, collaboration and empowerment (Fallot and Harris, 2001)
- accommodate the vulnerabilities of trauma survivors including people from diverse backgrounds
- minimise the risks of re-traumatisation and promote healing
- emphasise physical and emotional safety for everyone
- recognise coping strategies as attempts to cope
- collaborate with clients, and affirm their strengths and resources
- recognise the importance of respect, dignity and hope
- focus on the whole context in which a service is provided and not just on what is provided.[223]

[218] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[219] Kezelman C, 'Trauma informed practice,' *Mental Health Australia*, 2014, viewed 26 October 2021 <https://mhaustralia.org/general/trauma-informed-practice>.
[220] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[221] Fallot R and Harris M, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2009, Community Connections, Washington DC, p. 2.
[222] Queensland Government, *Trauma-Informed Care and Practice: A guide to working well with Aboriginal and Torres Strait Islander Peoples*, 2019, p. 3.
[223] Blue Knot Foundation, 'Building a Trauma-Informed World', 2021, viewed 4 November 2021 <https://blueknot.org.au/resources/building-a-trauma-informed-world/>.

7.2.1 Key principles of trauma informed approaches

Frameworks articulating trauma informed approaches to service provision identify a set of key principles underpinning these approaches. 'Although at times there might be subtle variations in terminology, and a degree of overlap between the principles, there is general congruence' around five key principles of trauma informed approaches.[224] These principles include:

SAFETY:	Ensuring physical and emotional safety
TRUSTWORTHINESS:	Maximising trustworthiness through task clarity, consistency, and interpersonal boundaries
CHOICE:	Maximising consumer choice and control
COLLABORATION:	Maximising collaboration and sharing power
EMPOWERMENT:	Prioritising empowerment and skill building.[225]

7.2.2 Trauma and violence informed approaches acknowledge the impact of systemic inequalities and violence

In acknowledging that violence and abuse occurs within broader structural systems and inequalities, researchers have identified that frameworks for trauma and violence informed approaches 'expand the concept of trauma informed practice to account for the impact of systemic and interpersonal violence and inequalities have on a person's life.'[226]

> **Trauma-informed care (TIC)** creates safety for service users by understanding the effects of trauma, and its close links to health and behaviour; it is not about eliciting or treating people's trauma.
>
> **Trauma- and violence-informed care (TVIC)** expands on this to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life, emphasizing both historical and ongoing violence and their traumatic impacts. It shifts the focus to a person's experiences of past and current violence so problems are seen as residing in both their psychological state, and social circumstances.[227]

The research literature highlights that this shift in language also allows for 'a more expansive understanding of people's experiences of violence and trauma,' as, particularly in the case of complex trauma, 'histories of violence typically include interconnected experiences of interpersonal and systemic violence.' Further, 'for many victims, interpersonal violence is ongoing; it can be intergenerational and linked to broader historical contexts.'[228]

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[224] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 24.
[225] Adapted by Ombudsman Western Australia from: Fallot R and Harris M, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2009, Community Connections, Washington DC, p. 7-10; Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 8; Kezelman C and Stavropoulos P, *Talking About Trauma: Guide to Everyday Conversations for the General Public*, p.12-23; and Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 11.
[226] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.
[227] Wathen C and Varcoe C, *Trauma- & Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations & Providers*, 2021, Gender, Trauma & Violence Knowledge Incubator @ Western University and Equip Health Care, London, Canada, p. 1.
[228] Ponic P, Varcoe C and Smutylo T, *Trauma-(and Violence-) Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations (Victims of Crime Research Digest No. 9)*, 2018, Department of Justice, Ottawa, viewed 8 November 2021 <https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html>.

7.2.3 Trauma informed, culturally strong healing approaches

The research literature highlights the importance of trauma informed approaches respecting diversity and ensuring cultural competency, identifying that a trauma informed approach 'understands how cultural context influences perception of and response to traumatic events and the recovery process,' and uses interventions respectful of and specific to cultural backgrounds, leveraging the healing value of traditional cultural connections.[229]

In highlighting that trauma informed approaches 'need to be responsive to cultural, historical, and gender issues,' researchers also highlight that this includes 'the provision of gender-responsive services, or considering gender-specific needs when interacting with individuals.'[230]

An example of a 'community centred, culturally strong, trauma-informed' framework for strengthening community capacity to end violence has been developed by the Ngaanyatjarra Pitjantjatjara Yankunytajatjara (NPY) Women's Council together with the Australian Childhood Foundation.[231] As noted by the Australian Human Rights Commission Report *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, this practice framework:

> … contains a strong commitment to resourcing communities with the tools to build and develop their own strategies based in their knowledge systems, stories, ceremonies, healing practices and spiritual beliefs to challenge violence and find safety in their lives.
>
> The Framework is useful in understanding what forms of working practices are considered trauma-informed and appropriate for Indigenous organisations to deliver.
>
> The Framework consists of eleven stages of actions and strategies which should be approached gradually and with care by practitioners in a linear order. Each stage of the Framework has a set of actions, strategies and practical information for the family violence practitioner to guide and evaluate their work.[232]

7.2.4 Victims and witnesses of violent crime have diverse and varied needs for support

In recent years, a number of Australian reviews and inquiries have been conducted into the needs and experiences of victims. Most notably, these have included the Royal Commission into Institutional Responses to Child Sexual Abuse, and the Victorian Royal Commission into Family Violence. The reports of these inquiries have provided new perspectives on victims' experiences, support needs, and the re-traumatisation that can arise from inadequate systemic responses.

[229] Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 8; Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 11.
[230] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.
[231] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney, p. 141.
[232] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney, p. 141-142.

Accordingly, the evidence base on victims' needs and experiences has expanded in recent years, broadening understandings of victimisation and trauma beyond

> … an understanding of crime as an isolated or confined experience from which victims of crime are well equipped to recover; that victims experience crime with few pre-existing issues; and that victims of crime are always able to identify and articulate what they need from the system.[233]

It is now well recognised that victims of crime have diverse needs and experiences of victimisation, and may have multiple and/or complex support requirements – all of which occur in the broader context of their life circumstances, historical interactions with support services and pre-existing vulnerabilities.[234]

7.3 Victims of family and domestic violence who died by suicide had significant contact with State government departments and authorities, demonstrating significant demand for crisis services in the absence of available longer-term support

Western Australia's Aboriginal Empowerment Strategy identifies that 'government services generally fall into three basic categories, based on how intensive, urgent or reactive they are. Different sectors use different terminology for these categories (and different numbers of categories), however the table below shows the key basic characteristics:'[235]

[233] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: victim Services Review: Final Report,* 2020, RMIT University, p 12, viewed 27 May 2022, <https://cij.org.au/cms/wp-content/uploads/2020/11/strengthening-victorias-victim-support-system-victim-services-review-centre-for-innovative-justice-november-2020.pdf>
[234] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: victim Services Review: Final Report*, 2020, RMIT University, p 21-23, viewed 27 May 2022, <https://cij.org.au/cms/wp-content/uploads/2020/11/strengthening-victorias-victim-support-system-victim-services-review-centre-for-innovative-justice-november-2020.pdf>
[235] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, Department of Premier and Cabinet, p. 32.

Table 2: Types of Government Services, as identified in Western Australia's Aboriginal Empowerment Strategy

Primary Preventative Universal Resilience	Secondary Restorative / Early intervention Targeted Stabilisation	Tertiary Reactive Mandatory/Statutory Crisis
Support wellbeing, foundational needs and capacities, inclusion, and protective factors, before issues arise	Reduce vulnerability and the risk factors leading to the need for crisis response	Provide safety and protection of self or others from identified risk
EXAMPLES • Parenting and early years • Youth recreation • Cultural programs and healing • Education and skills • Community infrastructure • Public health initiatives • Safe and stable housing	EXAMPLES • Youth Diversion • Youth diversion programs • Tenancy supports • Financial counselling • Rehabilitation facilities • Family counselling	EXAMPLES • Prisons • Hospitals • Children in out-of-home care • Women's refuges

Source: Aboriginal Empowerment Strategy[236]

7.3.1 The underlying drivers of demand for crisis-oriented service provision are also inherently related to suicide prevention

Key Western Australian inquiries and strategic frameworks have highlighted the need to address the underlying drivers of demand upon crisis responses, including in the context of suicide prevention, including:

- the State Coroner's 2017 *Inquest into the deaths of 13 children and young persons in the Kimberley*;[237]
- Western Australia's Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 in Western Australia;[238] and
- Western Australia's Aboriginal Empowerment Strategy.[239]

[236] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, Department of Premier and Cabinet, p. 32.
[237] State Coroner, *Inquest into the deaths of 13 children and young persons in the Kimberley*, 2017, Coroner's Court of Western Australia, p. 33.
[238] Government of Western Australia, *Emerging Directions: The Crucial Issues For Change*, 2021, Ministerial Taskforce into Public Mental Health Services for Infants, Children, and Adolescents aged 0-18 in Western Australia, p. 6.
[239] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, Department of Premier and Cabinet, p. 33.

7.4 Some Australian jurisdictions include the association between family and domestic violence and suicide in strategic frameworks

The Office identified that in some other Australian jurisdictions, significant work has been undertaken to incorporate knowledge about the association between family and domestic violence and suicide into relevant strategies and frameworks, including in the:

- Victorian *Family Violence Multi-Agency Risk Assessment and Management Framework* (**the MARAM Framework**), which 'aims to address the gaps identified by the Commission' and 'provides a system-wide approach to risk assessment and risk management;'[240] and
- Queensland *Suicide prevention framework for working with people impacted by domestic and family violence.*[241]

7.4.1 There is some recognition of the association between family and domestic violence and suicide in Western Australian strategic frameworks

The Office identified that some Western Australian strategic frameworks recognise the association of family and domestic violence and suicide, including:

- *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* identifies that 'family and domestic violence towards children, young people, and adults is a primary cause of … suicide and self-harm;'[242]
- the Western Australian Suicide Prevention Framework, which acknowledges 'the role that addressing historical and current trauma and the social determinants of health have in suicide prevention;'[243] and
- the State government's draft Aboriginal Family Safety Strategy. [244]

On 22 July 2020, the State Government launched *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* (**Path to Safety**), Western Australia's strategy for reducing and responding to family and domestic violence.

The Path to Safety framework for change has 'four focus areas:'

- work with Aboriginal people to strengthen Aboriginal family safety;
- act immediately to keep people safe and hold perpetrators to account;
- grow primary prevention to stop family and domestic violence; and
- reform systems to prioritise safety, accountability and collaboration.[245]

[240] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5; Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 3.
[241] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 1-2.
[242] Department of Communities**,** *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, Government of Western Australia, p. 17.
[243] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, Government of Western Australia, p. 24.
[244] Government of Western Australia, 'Aboriginal Family Safety Strategy released for comment', *Media Statements*, 17 March 2022, accessed 17 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Aboriginal-Family-Safety-Strategy-released-for-comment.aspx>.
[245] Government of Western Australia, *Western Australia's Strategy to Reduce Family and Domestic Violence,* 2021, viewed 15 December 2021 <https://www.wa.gov.au/government/publications/western-australias-strategy-reduce-family-and-domestic-violence>.

Path to Safety will be supported by three action plans 'that set out what needs to be done to achieve the long-term vision of all Western Australian's living free from family and domestic violence.' The First Action Plan, running from July 2020 to June 2022, initially focuses on 'actions to address the significant impact of COVID-19 on family and domestic violence in Western Australia.'[246]

Recommendation 6: The Department of Communities, in consultation with key government and non-government stakeholders, considers this investigation and incorporates the findings of the investigation into strategic initiatives aimed at reducing the incidence and impact of suicide and self-harm associated with family and domestic violence, including incorporation into Path to Safety beyond the First Action Plan.

7.4.2 The Family and Domestic Violence Response Team Model was in place at the time of the investigation, and is currently being redesigned

As part of Western Australia's approach in assessing and responding to family and domestic violence, FVIRs are provided to a multi-agency team comprising representatives from WA Police, the Department of Communities, and non-government organisations for triage, assessment, and further action. This model, known as the Family and Domestic Violence Response Team (**FDVRT**) model, became operational in February 2013.[247] It was therefore in place approximately four years prior to the commencement of the investigation period, when 711 (56 per cent) of the 1,276 FVIRs relating to the individuals who died by suicide were recorded.

In August 2020, the Department of Communities released the findings of the Family and Domestic Violence Response Team Review Report (**the Review Report**), summarising key themes and findings of a review undertaken into the operation of FDVRTs. The Review Report identified that 'the review of the FDVRT model was conducted as a result of the Ombudsman Western Australia (OWA) findings in relation to various child death and family and domestic violence (FDV) fatality reviews that identified recurring issues with the FDVRT model. In addition, known issues have been identified through operational and contract management feedback.'[248]

The Review Report highlighted a number of findings, including that 'there is an urgent and critical need for a focussed team to support and guide the FDVRT with appropriate governance, monitoring, and compliance processes.'[249]

In July 2021, government stakeholders including the Minister for Police, Hon Paul Papalia and the Minister for Prevention of Family and Domestic Violence, Hon Simone McGurk met with the Director General, Communities to discuss interagency Family and Domestic Violence responses.'[250]

[246] Government of Western Australia, *Western Australia's Strategy to Reduce Family and Domestic Violence*, 2021, viewed 15 December 2021 <https://www.wa.gov.au/government/publications/western-australias-strategy-reduce-family-and-domestic-violence>.
[247] Department of Communities, *Family and Domestic Violence Response Team Operating Procedures*, 2017, p. 4.
[248] Smith P, *Family and Domestic Violence Response Team Review*, 2020, Thirdforce Consultancy Services Pty Ltd, p. 6.
[249] Smith P, *Family and Domestic Violence Response Team Review*, 2020, Thirdforce Consultancy Services Pty Ltd, p. 8.
[250] Personal Communication, Department of Justice, 4 November 2021 and Personal Communication, Department of Communities, 29 October 2021.

During the investigation, the Department of Communities advised the Office that:

> The FDVRT Project will be guided by the Aboriginal Family Safety Strategy, which is currently in development, and apply the principles and critical components of the nationally and internationally recognised Safe and Together model. Over the past two months, the project team has met fortnightly to develop a project plan which outlines the agreed principles and considerations which will guide the Project. This draft project plan was reviewed and endorsed by the committee on 2 September 2021.[251]

In December 2021, the Department of Communities most recently informed the Office that:

> … the project team have finalised the design of the enhanced Family Domestic Violence Response Team (FDVRT) service delivery model.
>
> The project team includes representatives from Communities, Justice and Police who have worked consultatively to implement the agreed deliverables, including
>
> - The inclusion of Justice Officers in the co-located FDVRT
> - Development of a Central Support and Coordination Team to provide governance of the model and ensure ongoing continuous improvement across the structure, policy, process and training. This is a tripartite arrangement, staffed by representatives of Communities', Police and Justice.

Recommendation 7: The Department of Communities, Western Australia Police Force and the Department of Justice, in consultation with key government and non-government stakeholders consider this investigation and incorporates the findings of this investigation in the redesign of the Family and Domestic Violence Response Team Model including, but not limited to:

- the association between family and domestic violence and suicide, for women and children;
- the association between family and domestic violence and suicide for Aboriginal and Torres Strait Islander women and children; and
- the need to see and speak to children and adolescents who are exposed to family and domestic violence when engaging with families and assessing risk, including those alleged to be the perpetrator or instigator of parent-child conflicts.

7.5 Some Western Australian strategic frameworks identify the need for trauma informed approaches to service provision

Key Western Australian strategy documents in the area of suicide prevention, family and domestic violence, engaging with young people, empowering Aboriginal and/or Torres Strait Islanders, and workforce development recognise the significance of trauma and its impact upon individuals and communities.

[251] Personal Communication, Department of Communities, 29 October 2021.

These strategy instruments also emphasise the need for services to adequately understand and appropriately respond to trauma, including:

- *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, which identifies that Western Australian responses to family and domestic violence will be trauma-informed;[252]
- the *WA Suicide Prevention Framework*, which specifies the need for trauma informed supports;[253]
- the *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, which identifies that services to young people must be trauma informed, and emphasises the need for all staff delivering services to young people are appropriately trained;[254]
- the *Aboriginal Empowerment Strategy*, which identifies that healing trauma is an essential part of the strategy, emphasising trauma informed service delivery;[255] and
- Western Australia's *Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, which identifies that implementation of trauma-informed care is necessary across health and human service systems, not just within mental health and alcohol and other drug settings.[256]

7.5.1 The Office did not identify detailed public sector guidance about what it means to be trauma informed

The Office identified that these strategies and frameworks recognise the importance of understanding trauma and identify the importance of trauma informed service delivery. However, the Office did not identify a unified whole of government service approach or framework for creating shared definitions and understandings of trauma informed practice, its implementation and evaluation.

In other countries and in Australia, some agencies are 'moving towards a trauma-informed paradigm for considering health and human service delivery systems.'[257]

Researchers acknowledge that the implementation of trauma informed approaches at 'the systems level' is challenging 'due to the complex, dynamic nature of service systems.'[258] While the term 'trauma informed' is common, and used frequently across a range of service settings, some researchers highlight that 'there is not a common understanding of [trauma informed care],' or of how to implement it in different service settings. This 'causes confusion and difficulties in integrating and coordinating service delivery across sectors.'[259]

[252] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, p. 6.
[253] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[254] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 20.
[255] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 11.
[256] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, 2020, p. 48.
[257] Wall L, Higgins D, and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, Australian Institute of Family Studies, p. 12.
[258] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 38.
[259] Domestic Violence Victoria, 'DV Vic Submission to Mental Health Royal Commission,' 2019, p. 19.

The research literature identifies that, while take-up of the idea of trauma informed approaches has been enthusiastic, 'leadership on framing trauma-informed care and collaborative initiatives to design, implement and evaluate organisational and systemic approaches are essential.'[260]

Recommendation 8: The Mental Health Commission, in collaboration with relevant State government departments and authorities and stakeholders, develop and disseminate a common understanding of what constitutes a trauma informed approach for Western Australian State government departments and authorities. Including, but not limited to:

- a definition and key principles of a trauma informed approach;
- domains of implementation (including, but not limited to, an organisation's strategic leadership, policy, training for staff, and evaluation);
- consideration of vicarious trauma in the service delivery context;
- this approach being intersectional, and elevates the voices and experiences of Aboriginal and/or Torres Strait Islander people; and
- a timeline for undertaking this work.

7.6 Operationalising what it is to be trauma informed will vary across settings and systems

Researchers exploring the operation of frameworks for trauma informed approaches emphasise that 'a shared understanding about the overall philosophy and purpose of trauma-informed care [or practice]' and appropriate support 'to realise this paradigm shift' is crucial.[261] Trauma informed approaches 'must be based on principles, policies, and procedures that provide safety, voice and choice.'[262]

However, principles of trauma informed practice are not prescriptive, 'and cannot be given the wide range of possible service contexts in which they may be applied.'[263] In this context, the research literature highlights that an aspect of trauma informed approaches is that they 'must be culturally relevant' to the population served.[264]

> The core idea behind trauma-informed systems is that they are relational, and human... It will also be difficult for others to prescribe. Each service, organisation and individual will need to work through how they can embrace the principles of trauma informed care, and then apply them in non-static ways to best meet the needs of the person in front of them.[265]

[260] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 36.
[261] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p.39-41
[262] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 27.
[263] Jackson A and Walters S *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, p. 18.
[264] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, Australian Institute of Family Studies, p. 13.
[265] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 8.

In identifying that the principles and practices of a trauma informed approach must be translated in a way that is relevant for unique service settings, researchers also identify that the nature of a trauma informed approach transcends isolated policies or procedures and may instead be used 'as a lens through which to focus on, create and then review all policies and procedures.'[266]

While the adoption of trauma informed approaches therefore requires leadership, guidance, and visibility about how this is being implemented, what it means to practice a trauma informed approach will vary in different settings. Accordingly, researchers identify that, to some extent, variability in how trauma informed approaches are 'translated into practice or operationalised in different settings' is expected.[267]

Translating trauma informed approaches into practice also involves considering the needs of distinct workforces, and how staff in different settings engage with individuals, information, and are exposed to trauma.

In identifying that the implementation of a trauma informed approaches is a 'paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time,' researchers have identified a continuum of implementation for organisations increasing their awareness of trauma. This continuum of implementation begins 'with becoming trauma aware and … [moving] to trauma sensitive to responsive to being fully trauma informed.'[268]

1. **Trauma aware:** where staff understand trauma and how individuals may have behavioural presentations in response to traumatic experiences.

2. **Trauma sensitive**: where an organisation's work practice can operationalise some concepts of a trauma-informed approach.

3. **Trauma responsive**: where the individual and organisational response enables changes in behaviour and strengthens resilience and protective factors.

4. **Trauma-informed**: where the culture of the whole system reflects a trauma-informed approach in all work practices and settings.[269]

Recommendation 9: Taking into account the outcome of Recommendation 8, the Western Australia Police Force; the Department of Justice; the Department of Health; and the Department of Communities each:

- consider how a trauma informed approach may be incorporated into their operations; and
- work to improve their organisation's understanding of trauma.

[266] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, p. 39.
[267] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.
[268] Missouri Department of Mental Health, 'Missouri Model: A Developmental Framework for Trauma Informed Approaches,' 2019, p. 1, viewed 11 November 2021 <https://dmh.mo.gov/media/pdf/missouri-model-developmental-framework-trauma-informed-approaches> and Blue Knot Foundation, 'Foundations for Building Trauma Awareness: Professional Development Training Booklet', delivered 17 September 2021.
[269] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, p. 38.

Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	October 2022
A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee	September 2022
A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020	September 2021
An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	July 2021
Preventing suicide by children and young people 2020	September 2020
A report on giving effect to the recommendations arising from 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

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Investigation into family and domestic violence and suicide

Volume 2: Understanding the impact of family and domestic violence and suicide

Ombudsman Western Australia

About this Report

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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 emerging.

CONTENT WARNING

This report contains information about suicide, family and domestic violence 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 women and children who died by suicide.

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Getting help and finding support

If a life is in danger, or someone you know is at immediate risk of harm, call 000.

If you, or someone you are with is highly distressed, feeling unsafe and thinks they are a risk to themselves, go to your nearest emergency department.

If you are worried about a person who refuses to go to an emergency department, and need urgent mental health assistance, please contact:

Mental Health Emergency Response Line: 1300 55 788 (Perth) or 1800 676 822 (Peel)

rapid response for after-hours mental health emergencies in the Perth and Peel metro areas, or connection to your local mental health service during business hours

Rurallink: 1800 552 003 (regional Western Australia, free call)

specialist after hours mental health telephone service for people in rural communities, 4.30 pm to 8.30 am, Monday to Friday and 24 hours Saturday, Sunday and public holidays, and for connection to your local mental health service during business hours

Suicide Call Back Service: 1300 659 467 or suicidecallbackservice.org.au

free phone, video and online counselling for people at risk of suicide, concerned about someone at risk, bereaved by suicide and people experiencing emotional or mental health issues

Child and Adolescent Mental Health Service Crisis Connect: 1800 048 636

phone and online videocall support for children and young people experiencing a mental health crisis as well as support and advice to families and cares, available seven days a week from 8.30 am to 2.30 pm across the Perth metro area

Australia-wide 24 hour mental health support lines

Lifeline: 13 11 14 or lifeline.org.au

24 hour telephone crisis support and suicide prevention online crisis support chat available from 7 pm to midnight AEST

13 YARN 13 92 76

the first national crisis support line for mob who are feeling overwhelmed or having difficulty coping, they offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal & Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week

Beyond Blue: 1300 22 4636 or beyondblue.org.au

immediate support available 7 days a week, through phone (24 hours), online chat (3 pm to 12 am) or email (response within 24 hours)

1800RESPECT: 1800 737 732 or 1800respect.org.au

24 hour phone and web chat counselling for people impacted by sexual assault, domestic or family violence and abuse

MensLine Australia: 1300 78 99 78 or mensline.org.au

phone, video and web counselling for men who want to take responsibility for their violence and have healthy and respectful relationships

StandBy Support After Suicide: 1300 72 77 47

a program focused on supporting anyone who has been bereaved or impacted by suicide at any stage in their life

Additional support services

Women's Domestic Violence Helpline: 1800 007 339

provides support for women, with or without children, who are experiencing family and domestic violence in Western Australia (including referrals to women's refuges)

Men's Domestic Violence Helpline: 1800 000 599

provides telephone information and referrals for men in Western Australia who are concerned about their violent and abusive behaviours

Crisis Care: 9223 1111 or 1800 199 008

provides Western Australia's after-hours response to reported concerns for a child's safety and wellbeing and information and referrals for people experiencing crisis

Sexual Assault Resource Centre: (08) 6458 1828 or freecall 1800 199 888

provides a range of free services to people affected by sexual violence

Derbarl Yerrigan Health Service: 9241 3888 or dhys.org.au

health and medical support for Aboriginal people, including counselling, Mon-Fri 9 am to 5 pm

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

phone, web chat or email counselling support for people affected by complex mental health issues, available from 10 am to 10 pm AEST

GriefLine: 1300 845 745 (landlines) or (03) 9935 7400 (mobiles) or griefline.org.au

free phone counselling and support for people experiencing grief, loss and trauma, 6 am to midnight AEST, seven days a week

Active Response Bereavement Outreach (ARBOR): 1300 11 44 46 or arbor.bereavement@anglicarewa.org.au

a free service offering short-medium term grief counselling, practical & emotional support, appropriate referral support, volunteer lived-experience peer support, and support groups to people recently impacted by losing loved ones to suicide

QLife: 1800 184 527 or qlife.org.au

3 pm to midnight, 7 days per week, telephone and webchat counselling for LGBTI people

Support services for children and young people

Kids Helpline: 1800 55 1800 or kidshelpline.com.au

24 hour telephone and web chat support for kids, teens and young adults from 5 to 25 years and their parents, carers, teachers, and schools

headspace: headspace.org.au/eheadspace

free telephone and online support and counselling for children and young people 12 to 25 years, their families and friends

Children and Young People Responsive Suicide Support (CYPRESS): 1300 11 44 46 or info@anglicarewa.org.au support service for children and young people between the ages of 6 and 18 who have been bereaved by suicide

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1 Family and domestic violence and suicide

1.1 The research literature

1.1.1 Suicide is preventable

Suicide can be prevented, as highlighted by the World Health Organization, the United States Centers for Disease Control and Suicide Prevention Australia.[1] Government departments and authorities have a key role in preventing suicide in our community, as noted recently by Australia's National Suicide Adviser, Christine Morgan:

> Governments can do much for suicide prevention. There is the potential at every level and across each portfolio to identify aspects of suicide prevention that relate to existing responsibilities. There are improvements that can be made to better equip the workforces involved in the delivery of services. Governments, however, cannot and should not do everything on suicide prevention. We also need those in business and in community spheres of influence to examine how they can make a contribution that complements government action.[2]

1.1.2 Many complex factors can influence suicide risk, or create safety and prevent suicide

The research literature offers no simple explanations for suicide, with scientific evidence highlighting a range of risk factors for suicide and suicidal behaviour including mental illness, previous self-harm or suicide attempts, substance abuse disorders, adverse childhood experiences, and stressful life events or crises.[3] As noted by Suicide Prevention Australia, effective suicide prevention requires a whole of government approach to address the 'social, economic, health, occupational, cultural, and environmental factors' that can lead a person to significant distress and suicidal behaviours:

> Suicide is a complicated, multi-factorial human behaviour and is more than an expression of mental ill health. Only half of those who tragically lose their life to suicide each year are accessing mental health services at the time. Recent modelling released by the Australian Institute of Health and Welfare revealed socio-economic factors such as being widowed, divorced or separated, being not in the labour force or being unemployed, being a lone person household and being male, to be risk factors that had the strongest associations with suicide.
>
> As noted in the Interim Report of the National Suicide Prevention Advisor: "no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress".
>
> Preventing suicide therefore requires a holistic, cross-governmental approach that effectively coordinates funding and policy attention to address the social, economic, health, occupational, cultural, and environmental factors involved. This

[1] World Health Organization, *Key facts: Suicide*, 17 June 2001, <https://www.who.int/news-room/fact-sheets/detail/suicide>; Stone DM, Holland KM, Bartholow B, Crosby AE, Davis S, and Wilkins N, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control*, 2017, Centers for Disease Control and Prevention; Suicide Prevention Australia, 'Our ambition', <https://www.suicidepreventionaust.org/our-ambition/>.
[2] National Suicide Prevention Taskforce, *Final Advice: Connected & Compassionate – Implementing a national whole of governments approach to suicide prevention*, Australian Government, December 2020, p 1.
[3] MacIsaac M, Bugeja L, and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61; Fuller-Thomson, Baird SL et al, 'The association between adverse childhood experiences (ACEs) and suicide attempts in a population based study,' *Child: care, health and development*, 42(5), p. 725; and Commission for Children and Young *People (Victoria), Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 8.

> includes consideration of suicide prevention in issues as diverse as housing, employment, and helping people to build healthy social connections.[4]

Although commonly used, suicide 'risk assessment tools' linking demographic risk factors to suicide risk have been found by a British Medical Journal 'state of the art' review of suicide risk assessment and intervention as having been developed without a solid evidence base.[5] Further, the United Kingdom Royal College of Psychiatrists has noted that:

> Current suicide risk assessment tools mainly use demographic risk factors (which may be as common in the general population) and have largely been developed without a solid empirical basis. …The reliance upon risk factor identification fails both clinicians and patients.
>
> Our understanding of which factors differentiate those who will have thoughts of suicide from those who will act upon those thoughts and attempt suicide is still elementary. Demographic risk factors increase the suicide risk of a whole population across its lifetime, but do not predict suicide in an individual at a single time-point. Furthermore, suicide risk assessment is itself a complex intervention, unpredictable, with the process influenced by practitioner, patient and organisational factors.
>
> While suicide rates vary significantly among different demographic groups, a review of suicide risk assessments in 2015 found that demographic factors are unable to predict suicide risk accurately and should not be relied upon. A person may still be at high risk of suicide even though they might not be assessed as a member of a high-risk group.
>
> Conversely, not all members of high-risk groups are equally at risk of suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period.[6]

There is, however, 'strong evidence' which demonstrates that previous suicide attempts and self-harming behaviours are significant risk factors for suicide:

> … the risk of suicide among those who have self-harmed is much greater than that of the general population, as is the risk of premature death. Almost half of the general population and over half of young people who end their life by suicide, have previously harmed themselves. …
>
> The risk of suicide is elevated by between 30 and 100 fold in the year following an episode of self harm, compared to the general population (Chan et al. 2016).
>
> 20% of people who attend hospital after self-harming repeat this behaviour within a year, many returning to the same hospital (Kendall et al. 2011). One in 50 patients who attend hospital after self-harm will die by suicide within one year and one in 15 within nine years (Owens, Horrocks & House, 2002). More than 50% of people who die by suicide have self-harmed, 15% within the previous year (Gairin, House & Owens, 2003). People who self-harm also have a higher all-cause mortality, i.e. not just from suicide (Bergen et al. 2012).[7]

[4] Suicide Prevention Australia, *2022-23 Pre-Budget Submission*, January 2022, p. 11.
[5] Bolton JM, Gunnell D and Turecki G, 'Suicide risk assessment and intervention in people with mental illness', BMJ, 2015;351:h4978 <http://dx.doi.org/10.1136/bmj.h4978>.
[6] Royal College of Psychiatrists, *Self-harm and suicide in adults: Final report of the Patient Safety Group* (CR229), July 2020, p. 28-29.
[7] Royal College of Psychiatrists, *Self-harm and suicide in adults: Final report of the Patient Safety Group* (CR229), July 2020, p. 30-31.

Those bereaved by suicide are also recognised as being at elevated risk of suicide:

> Not only is there robust empirical evidence to support the elevated risk of suicide in people bereaved by the suicide of a child (Qin & Mortensen 2003), partner (Agerbo 2015, Erlangsen et al. 2017), or parent (Garssen et al. 2011) compared to those bereaved by other causes, but also evidence of greater perception of stigma (Pitman et al. 2014). This has help-seeking implications, particularly as those in need of support may not always be next of kin, and the elevated risk of a suicide attempt applies whether a person was related to the deceased or not (Pitman et al. 2016). Indeed, the negative effects of suicide bereavement can affect relatives, friends, partners, and the professionals who cared for that person before their death. Those who are less visible, such as children, ex-partners, and more peripheral friends, are described as the 'hidden bereaved'. They can experience disenfranchised grief that is not socially sanctioned or openly acknowledged, yet they too are in need of support.[8]

Suicide is also increasingly recognised as occurring 'more frequently with the coexistence of psychiatric and physical illness:'

> In primary care patients studies have shown higher suicide risk with coronary heart disease, stroke, COPD, and osteoporosis (Webb et al. 2012). Women with cancer or coronary heart disease have an elevated risk of suicide independent of clinical depression. Risk of suicide is greater in younger, physically ill women and in older women with multimorbidity. Most people who die by suicide late in life have recognised clinical depression. …
>
> We know that the risk of self-harm is raised across a wide variety of physical illnesses in both genders, and particularly so in women. Using the General Practice Research Database, Webb and colleagues (2012) found significantly higher risk of self-harm in patients with asthma, back pain, COPD, coronary heart disease, diabetes, epilepsy, hypertension, osteoarthritis and stroke (Webb et al. 2012). Depression explained 57% of the elevated risk among all patients diagnosed with one or more LTCs. Depression raised the risk of self-harm in two thirds of men and half of women. The risk remained elevated in women with asthma, back pain, diabetes, epilepsy or hypertension, even after adjustment for depression.[9]

In the Australian context, the AIHW has noted that:

> Capturing information on risk factors relating to deaths by suicide can highlight areas of a person's life experience that may need additional attention to provide the most effective suicide prevention interventions. However, it is important to note that the presence of one or more of these risk factors in an individual's life does not necessarily mean they will have suicidal behaviours. The vast majority of people who experience these risk factors will not experience suicidal behaviours.
>
> As part of the National Suicide and Self-harm Monitoring Project the AIHW has funded the Australian Bureau of Statistics (ABS) to identify and code (using ICD-10) psychosocial risk factors for deaths referred to a coroner, including deaths by suicide. …

[8] Royal College of Psychiatrists, *Self-harm and suicide in adults: Final report of the Patient Safety Group* (CR229), July 2020, p. 57.
[9] Royal College of Psychiatrists, *Self-harm and suicide in adults: Final report of the Patient Safety Group* (CR229), July 2020, p. 31.

From 2017 to 2020:

- the most commonly identified risk factor for males and females in all age groups except those 65 and over was a 'personal history of self-harm'.
- 'Limitation of activities due to disability' was the most commonly identified risk factor in males and females aged 65 and over.
- 'Disruption of family by separation and divorce' and 'problems in relationship with spouse or partner' were generally the second- and third-most common risk factors in males and females aged under 55.
- 'Problems related to other legal circumstances' was also a common risk factor in males aged 25–34, 35–44 and 45–54 (associated with more than 10% of deaths by suicide).
- 'Other problems relating to economic circumstances' also emerged as a common risk factor in middle-aged males (45–54 and 55–64; associated with more than 10% of deaths by suicide in these age groups).
- 'Disappearance and death of a family member' was also identified as a frequently occurring psychosocial risk factor in males and females.
- 'Prophylactic measure for pandemic response' (including closure of business and stay at home measures) appeared as a one of the most frequently occurring psychosocial risk factors in males aged 55–64 (associated with 4% of deaths by suicide in 2020) and females aged 25–34, 55–64 and 65 and older (associated with 4% to 6% of deaths by suicide in these age groups in 2020).[10]

For Aboriginal and Torres Strait Islander people, there are additional risk factors and impacts affecting both suicide risk and the effectiveness of suicide prevention interventions. Suicide among Aboriginal and Torres Strait Islander peoples 'was almost unheard of prior to the 1960s.'[11] The Wiyi Yani U Thangani Report identifies 'research shows that there is a difference in the nature of suicides and suicide attempts between Aboriginal and Torres Strait Islander peoples and other Australians:'

> Notably, there appears to be a relatively low correlation between Aboriginal suicide and diagnosable mental illness, where drug and alcohol misuse is considered separately. …
>
> The disproportionate rate of suicide in Aboriginal and Torres Strait Islander populations is in part attributed to higher levels of social and economic disadvantage, and increased exposure to known risk factors shared with the general population such as poverty, unemployment, homelessness, incarceration and family violence.[12]

[10] Australian Institute of Health and Wellbeing, *Suicide & self-harm monitoring: Psychosocial risk factors and deaths by suicide*, viewed 28 May 2022, <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide>.
[11] Dudgeon P, Cox A, Walker R, et al, *Solutions that Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*., 2016, School of Indigenous Studies, UWA, Perth, p. 6.
[12] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Canberra, p. 433.

These systemic disadvantages have been compounded by the persistence of institutional racism in Australian health and mental health systems, as detailed in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report.[13]

Importantly researchers identify that:

> While any one of these factors can increase the risk of suicide, suicide is rarely the consequence of one single cause but often the result of a combination of factors.[14]
>
> Further to this, "[t]he journey to suicide is complicated; it can span decades."[15]

1.1.3 Violence against women and children is a 'major public health problem and a violation of women's human rights' that is also preventable[16]

As noted by the World Health Organization, violence against women and children is a highly prevalent, worldwide, preventable social problem, with 'about 1 in 3 (30%) of women worldwide … subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.'[17]

Children living in homes with violence can 'suffer a range of behavioural and emotional disturbances … [and] higher rates of infant and child mortality and morbidity (through, for example diarrhoeal disease or malnutrition and lower immunization rates).'[18]

The World Health Organization and UN Women have developed seven key evidence-based strategies to prevent violence against women and girls. All of these strategies, when successfully implemented, start early in life and involve prioritising the safety of women, challenging gender inequities in power and relationships, and addressing multiple risk factors, as follows:

> In 2019, WHO and UN Women with endorsement from 12 other UN and bilateral agencies published *RESPECT women* – a framework for preventing violence against women aimed at policy makers.
>
> Each letter of RESPECT stands for one of seven strategies: Relationship skills strengthening; Empowerment of women; Services ensured; Poverty reduced; Enabling environments (schools, work places, public spaces) created; Child and adolescent abuse prevented; and transformed attitudes, beliefs and norms.
>
> For each of these seven strategies there are a range of interventions in low and high resource settings with varying degree of evidence of effectiveness. Examples of promising interventions include psychosocial support and psychological interventions for survivors of intimate partner violence; combined economic and social empowerment programmes; cash transfers; working with couples to improve communication and relationship skills; community mobilization interventions to

[13] Dudgeon P, Cox A, Walker R, et al, *Solutions that Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*., 2016, School of Indigenous Studies, UWA, Perth, p. 52.
[14] MacIsaac M, Bugeja L, and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61.
[15] Prof Vanessa Munro, University of Warwick's School of Law, quoted by Moore, A. 'Fatal truth: how the suicide of Alex Reid exposed the hidden death toll of domestic violence,' *The Guardian*, London, 24 March 2021, viewed 10 May 2021 <https://www.theguardian.com/society/2021/mar/24/fatal-truth-how-the-suicide-of-alex-reid-exposed-the-hidden-death-toll-of-domestic-violence>.
[16] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.
[17] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.
[18] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

> change unequal gender norms; school programmes that enhance safety in schools and reduce/eliminate harsh punishment and include curricula that challenges gender stereotypes and promotes relationships based on equality and consent; and group-based participatory education with women and men to generate critical reflections about unequal gender power relationships.[19]

1.1.4 Suicidal behaviour is highest among women and girls, who attempt suicide more frequently but die less frequently than men and boys

National statistics and studies on suicidal behaviour have consistently shown that women and girls engage in suicidal behaviour much more frequently than men and boys, although they are less likely to die from suicide than men.[20] The Australian Institute of Health and Wellbeing has noted that the morbidity burden associated with women and girls' suicidal behaviour has grown markedly in recent years:

> While males are more likely than females to die by suicide, females are more likely to be hospitalised for intentional self-harm (1.75 times); in 2016–17 females made up almost two-thirds (64%) of intentional self-harm hospitalisation cases (AIHW: Pointer 2019).
>
> In 2016–17, the age-specific rates of hospitalised injury cases for intentional self-harm peaked among females aged 15–19 at 686 cases per 100,000—nearly 4 times the rate for males in the same age group (180 per 100,000). The age-specific rates for females aged 0–14 and 15–24 rose markedly between 2007–08 and 2016–17, from 19 and 317 cases per 100,000 respectively in 2007–08 to 49 and 512 cases per 100,000 in 2016–17.[21]

Historically, there have been few studies on suicide focussed on suicidal behaviour in women and its association with gender differences, vulnerabilities, or psychosocial stressors, with some attempting to explain this research gap as arising from:

> … a tendency to view suicidal behavior in women as manipulative and nonserious (despite evidence of intent, lethality, and hospitalization), to describe their attempts as "unsuccessful," "failed," or attention-seeking, and generally to imply that women's suicidal behavior is inept or incompetent.
>
> The lack of investment in women's suicidal behavior may also arise from a global focus on the mortality of suicidal behavior (dominated by male deaths in all countries except China), with this focus on suicide leading to a relative under regard for morbidity (in which women predominate). … Suicide data fails to fully represent the major female contribution to morbidity. If both mortality and morbidity are considered together then it is evident that the weight of disease burden in suicidal behavior is clearly female.[22]

[19] World Health Organization, *Fact sheet: Violence against women*, 9 March 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.
[20] Australian Institute of Health and Wellbeing, *Injury in Australia: Intentional self-harm and suicide*, 9 December 2021 <https://www.aihw.gov.au/reports/injury/intentional-self-harm-and-suicide>; Devries K, Watts C, Yoshihama M et al, 'Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women', 2011, *Social science & medicine,* 73(1), p. 79-86.
[21] Australian Institute of Health and Wellbeing, *Australia's health 2020: Suicide and intentional self-harm*, 23 July 2020, <https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm>.
[22] Vijayakumar L, 'Suicide in women'," *Indian journal of psychiatry*, 2015, vol. 57,Suppl 2: S233-8. doi:10.4103/0019-5545.161484.

1.1.5 Suicide is linked to experiences of violence and injury, including gender-based violence, family and domestic violence, sexual abuse, physical abuse and abuse in childhood

Despite historical violence prevention research and prevention focussing on particular forms of violence, such as physical abuse, sexual abuse, psychological abuse and neglect, the United States Centres for Disease Control have long observed the need for a cross-cutting, strategic approach to preventing multiple forms of violence, due to the strong connection and relationship between them, including that:

- **Those who are victims of one form of violence are likely to experience other forms of violence**. There is evidence to suggest that experiencing one type of victimization can lead to a doubling or tripling of the risk for another type of victimization.

- **Those who have been violent in one context are likely to be violent in another context**. Youth who are violent toward peers, for example, are also more likely to be violent toward their dating partners. Adults who are violent toward their partners are also more likely to abuse their children.

- **The different forms of violence share common consequences. Beyond physical injuries and deaths these include a broad range of mental, emotional and physical health, and social problems that have effects across the lifespan**. Exposure to violence increases the risk of depression, post-traumatic stress disorder (PTSD), anxiety, sleep and eating disorders, and suicide and suicide attempts. There is also a strong association between violence and infectious diseases, especially HIV and other sexually transmitted infections. Multiple studies also document a number of reproductive consequences from exposure to violence, including unintended pregnancy and teen pregnancy, as well as associated risk behaviors, such as multiple partners and early initiation of sexual activity. Many of the leading causes of death—such as cancer, cardiovascular disease, lung disease, and diabetes—are linked to experiences of violence through the adoption of harmful alcohol use, tobacco use, and physical inactivity, and impacts on the brain, cardiovascular, immune and other biological systems. Beyond the chronic health effects, serious psychosocial effects of childhood violence are observed decades later, including severe problems with finances, family, jobs, anger, and stress.

- **The evidence also clearly shows that the different forms of violence share common risk and protective factors**. These factors can start in early childhood and continue across the lifespan. Many of the behavioral factors associated with perpetrating violence are evident well before 10 years of age, with signs of early physical aggression being one of the strongest predictors for later involvement in violent behavior, including violence against intimate partners. Early onset of sexual aggression is also one of the strongest predictors of subsequent sexual violence perpetration. Those who have been exposed to violence in the home are at increased risk for several forms of violence. Growing up and living in impoverished environments with limited social, educational, and economic opportunities and confronting the daily stresses of violence, racism, and instability at home or in the community also increases the risk of multiple forms of violence. Societal influences such as norms about violence, gender, and race/ethnicity, which are often rooted in customs, institutional practices and policies, impact health and opportunities and are associated with risk for multiple forms of violence. Connectedness, on the other hand, is protective across multiple forms of violence. Those who have

> stable connections to caring adults, affiliations with pro-social peers, and a strong connection to school and community are at lower risk for violence.[23]

Across Australia, research and reviews jurisdictions have identified an association between family and domestic violence and suicide, including in Queensland, where the Domestic and Family Violence Death Review and Advisory Board has observed that:

> … the relationship between suicidal ideation, threats and attempts, and violence perpetration within intimate partner or family relationships is not well understood, particularly its association with subsequent lethality. This is in part because of a paucity of research in this area.[24]

Despite there being an awareness of the association between family and domestic violence and suicide, researchers identify that 'it is a largely under-researched area,' and that among the existing research literature, 'there is a large degree of variability in the focus and methods employed, making direct comparisons problematic.'[25] There are some common limitations identified by researchers examining the research literature surrounding family and domestic violence and suicide. Researchers highlight a significant degree of diversity in samples, definitions, and measures employed in scientific literature.

Definitions and conceptualisations of family and domestic violence are subject to change, reflecting ongoing research and analysis. Early studies examining the association between family and domestic violence and suicide utilised limited definitions of family and domestic violence and focused primarily upon exposure to intimate partner violence or abuse, 'defined as any "incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners, regardless of gender or sexuality."'[26]

Definitions of intimate partner violence or abuse are also subject to change, with researchers identifying that 'much early research in this area was carried out with the assumptions that intimate partner abuse was synonymous with only physical abuse.'[27]

> The definitions of [intimate partner abuse] that are employed by the researchers have a significant impact on the measures that are used, and often influence which aspects of [intimate partner abuse] are focused on. These studies varied in which aspects of [intimate partner abuse] were measured, with the majority of studies focused solely on the physical aspects of abuse, whilst only three … also included psychological abuse.[28]

[23] Centres for Disease Control, *Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots. Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control*, 2016, p. 4-5.
[24] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 14-15.
[25] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, vol. 32, p. 678.
[26] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, vol.32, p. 678.
[27] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, vol.32, p. 678.
[28] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, vol. 32, p. 679.

The absence of uniform definitions concerning family and domestic violence in studies examining its association with suicide, 'both the relationships within which violence exposure occurs and the type of abuse experienced,' is identified as 'a major deficiency in the current research literature.'[29] Similarly, researchers highlight that measures of suicidality employed in studies relating to family and domestic violence are varied, 'often limited, with many studies using a single item to assess either suicidal ideation or suicide attempts,' and limited studies 'including more detailed measure[s] of suicidality.'[30]

Researchers further identify that much early research examining the association between family and domestic violence and suicide was carried out with assumptions, including the above perceptions of violence as relating to intimate partner abuse or violence and physical abuse only, and some further assumptions that this violence was synonymous 'with female victims and male perpetrators.'[31] Similar limitations were identified by the Queensland Domestic and Family Violence Death Review and Advisory Board, which, in a review relating to a family and domestic violence related suicide, identified that:

> The scientific literature regarding domestic and family violence and suicide generally focuses on two typologies: homicide-suicide and suicide by victims of domestic and family violence. For the most part, research has not explored the nature of suicide among perpetrators exclusive of homicide-suicides, despite evidence that domestic violence related suicides are more common than domestic violence related homicides.[32]

Samples used in studies examining the association between family and domestic violence and suicide are identified as an area of concern for researchers, noting that this has contributed to a 'dearth of literature relating to male victims of [intimate partner violence],'[33] and left the nature of suicide among perpetrators of family and domestic violence, exclusive of homicide-suicides, largely unexplored.

Due to heterogeneity in the current literature,[34] researchers identify that future research 'requires uniform definitions regarding types of violence and relationships between victim and perpetrator,' and measures of suicide and suicidality, to better enable targeted suicide prevention strategies.[35] Improving understandings of the relationship between 'suicidal ideation, threats and attempts, and violence perpetration within intimate partner or family relationships' is critical in strengthening responses to victims and perpetrators of family and domestic violence.[36]

[29] MacIsaac M, Bugeja L and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 67
[30] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 679.
[31] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 678.
[32] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p.15.
[33] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 685.
[34] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 677.
[35] MacIsaac M, Bugeja L and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 67
[36] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 15.

In responding to the need to advance knowledge and understanding, and to mitigate limitations in available research, researchers have undertaken systematic reviews that aim to identify, evaluate, and summarise individual studies undertaken concerning the relationship between family and domestic violence and suicide. Importantly, in acknowledging the limitations of existing, individual studies, systematic reviews have nonetheless identified 'a strong and consistent association between intimate partner abuse and suicidality,'[37] which is examined in further depth below.

1.1.6 There is a strong relationship between family and domestic violence and suicidality identified in the research literature

As identified, a significant portion of the research literature examining the association between family and domestic violence and suicide relates to intimate partner violence. In a systematic review of the research literature surrounding intimate partner violence and suicidality, McLaughlin et al identified 37 papers on the topic, and identified that:

> With only one exception… all of the studies found an association between [intimate partner violence/abuse] and suicidality. Importantly, this relationship held irrespective of method, sample and measurement of [intimate partner violence/abuse] and suicidality. Consequently, the degree of consistency in findings across these studies confirms a strong relationship between [intimate partner violence/abuse] and suicidality. This review highlights that intimate partner abuse is a significant risk factor for suicidal thoughts and behaviours, which has important clinical implications.[38]

Similarly, in a systematic review examining the research literature concerning the association between interpersonal violence and suicide among women, MacIsaac et al identified that 'being a victim or perpetrator of violence appears to be associated with risk of suicide.'[39]

1.2 The association between family and domestic violence and suicide in Australia

The association between family and domestic violence and suicide has been examined in other Australian jurisdictions. Crucially, this work is also based upon broad and inclusive definitions of family and domestic violence.

1.2.1 The Queensland Domestic and Family Violence Death Review and Advisory Board has identified that 'apparent suicides contribute the largest number of domestic and family violence deaths each year in Queensland'

In Queensland, the Domestic and Family Violence Death Review and Advisory Board, comprised of representatives of government and non-government organisations and chaired by the State Coroner, is responsible for 'the systemic review of domestic and family violence deaths in Queensland.'[40]

[37] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 677.
[38] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, volume 32, p. 685.
[39] MacIsaac M, Bugeja L and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61.
[40] Queensland Courts, *Review of deaths from domestic and family violence*, 2020, viewed 13 July 2020, <https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence>.

As part of this role, as established by section 91B of the *Coroners Act 2003*, the Domestic and Family Violence Death Review and Advisory Board also examines all apparent suicides that occurred in the context of family and domestic violence, where the person died by suicide or suspected suicide and 'was or had been in a relevant relationship with another person that involved domestic and family violence.'[41]

A relevant relationship, according to the *Coroners Act 2003* is defined as 'an intimate personal relationship, a family relationship or an informal care relationship, as defined under [the *Domestic and Family Violence Protection Act 2012*].'[42]

Recently, the Domestic and Family Violence Death Review and Advisory Board has reported that 'apparent suicides contribute the largest number of domestic and family violence deaths each year in Queensland, with 53 recorded in 2018-19 where there were clear links between domestic and family violence and the death:'[43]

> From 1 July 2015 to 30 June 2019, there have been 172 apparent domestic and family violence suicides recorded in Queensland.
>
> Broken down by financial year, this includes:
>
> - 30 apparent suicides in 2015-16
> - 51 apparent suicides in 2016-17
> - 38 apparent suicides in 2017-18
> - 53 apparent suicides in 2018-19.
>
> The vast majority of apparent suicides occurred in the context of intimate partner violence, with small numbers reported for family violence and where children were exposed to domestic and family violence in the household.[44]

The Queensland Government further highlights the association between family and domestic violence and suicide, particularly for females, in its recently released Suicide Prevention Framework for working with people impacted by family and domestic violence, noting:

> While suicide can affect all people, some people and groups are more vulnerable than others. Research indicates intimate partner violence is a significant risk factor for suicide in female victim/survivors, with some studies suggesting women who have been abused by their intimate partners are almost four times more likely to experience suicidal ideation compared to non-abused women in the general population. While threats of suicide may be used by a perpetrator as a form of domestic and family violence, many suicides that occur in the context of domestic and family violence involve the perpetrator taking their own life.[45]

[41] *Coroners Act 2003* (QLD), s. 91B(b).
[42] *Coroners Act 2003* (QLD), s. 91B(b).
[43] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and Family Violence Death Review and Advisory Board 2018-2019 Annual Report*, 2019, Queensland Government, Brisbane, p. 25.
[44] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and Family Violence Death Review and Advisory Board 2018-2019 Annual Report*, 2019, Queensland Government, Brisbane, p. 35.
[45] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 1.

1.2.2 The New South Wales Domestic Violence Death Review Team identified that almost half of female suicides examined in a pilot study 'had a recorded or apparent history of domestic and family violence, relationship conflict or relationship breakdown' (49 per cent)

The New South Wales (**NSW**) Domestic Violence Death Review Team is a multi-agency committee convened by the State Coroner, responsible for reviewing deaths that occur in the context of family and domestic violence in NSW.

In its 2015-2017 Report, the NSW Domestic Violence Death Review Team undertook a pilot study of domestic violence related suicides (that is, suicides where there is no murder or other domestic violence death associated). Whilst the NSW Domestic Violence Death Review Team has identified that this category of cases 'are not covered under the current legislative definition' and that 'due to limited resourcing and capacity issues within the Secretariat, this study has been unable to progress further,' the 2015-2017 report examined all suicides in the six-month period from 1 July 2013 to 31 December 2013, and found that:

> Of the 85 females who suicided, 33 (39%) had prior contact with NSWPF in relation to domestic or family violence (either as a victim, an offender, or both).
>
> For an additional 9 females, there was an apparent unreported history of domestic or family violence; proximal relationship conflict or evidence that their current relationship wad breaking down at the time of their suicide. This information was derived from the police narrative attached to the report of death.
>
> Accordingly, of the 85 female suicides in the reporting period, 42 (49%) had a recorded or apparent history of domestic and family violence, relationship conflict or relationship breakdown.[46]

1.2.3 Victorian research identified that 'forty-two percent of women who died from suicide had a history of exposure to interpersonal violence'

In Victoria, researchers conducted a retrospective study comprising 2,153 people who died by suicide between 1 January 2009 and 31 December 2012, aiming 'to determine the prevalence of [intimate partner violence] among people dying from suicide.' This research sought to determine 'the characteristics of victims and perpetrators of violence, according to the type of violence, the victim-perpetrator relationship, and the proximity of violence to death.'[47] Utilising data from the Coroner's Court of Victoria's Victorian Suicide Register, researchers identified that more than one-third of suicides in Victoria had a history of exposure to violence:

> Forty-two percent of women who died from suicide had a history of exposure to interpersonal violence, with 23% having been a victim of physical violence, 18% suffering psychological violence, and 16% experiencing sexual abuse.[48]

[46] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2017-2019*, 2019, New South Wales Government, Sydney, p. 140.
[47] MacIsaac M, Bujega L, Weiland T et al, 'Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia,' *Asia Pacific Journal of Public Health,* 2018, 30(1), p. 37.
[48] MacIsaac M, Bujega L, Weiland T et al, 'Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia,' *Asia Pacific Journal of Public Health,* 2018, 30(1), p. 36.

1.2.4 The Australian Burden of Disease Study showed a causal link between exposure to intimate partner violence to suicide and self-harm among Australian women

Burden of disease analysis 'quantifies the gap between a population's actual health and an ideal level of health – that is, every individual living without disease or injury to the theoretical maximum life span – in a given year' which:

> … reflects the direct relationship between a risk factor (for example, overweight and obesity) and a disease outcome. It is the amount of burden that could be avoided if the risk factor were removed or reduced to the lowest possible exposure.[49]

The Australian Burden of Disease Study 2015 (**ABDS**) 'estimated the amount of burden that could have been avoided if no women aged 15 and over in Australia in 2015 were exposed to' the risk factor of 'intimate partner violence.'[50] The ABDS estimated the burden due to partner violence 'only in women, as evidence in the literature to inform the causally linked diseases and the amount of increased risk (relative risk) was only available for women.'[51]

In estimating this burden, the ABDS, undertaken by the Australian Institute of Health and Welfare (**AIHW**), identified that six diseases were 'causally linked to exposure to intimate partner violence:'[52]

> If no female aged 15 and over had experienced partner violence in 2015 there would have been (among females aged 15 and over):
>
> - **41%** less homicide & violence (where females were the victim)
> - **18%** less early pregnancy loss
> - **19%** less suicide & self-inflicted injuries
> - **19%** less depressive disorders
> - **12%** less anxiety disorders
> - **4%** less alcohol disorders (AIHW 2019).[53]

The ABDS was repeated by AIHW in 2018, with the AIHW again examining the burden of intimate partner violence on Australian women. In undertaking this work, AIHW noted that to be included, 'the risk factor had to be modifiable, meaning that it could be prevented or modified through intervention and have sufficient evidence of a causal association between risk factor exposure and disease.'[54]

[49] Australian Institute of Health and Welfare, 'Burden of disease,' 2020, AIHW, Canberra, viewed 12 December 2021 <https://www.aihw.gov.au/reports/australias-health/burden-of-disease>.
[50] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story 2019*, 2019, p. 47.
[51] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story 2019*, 2019, p. 47.
[52] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story 2019*, 2019, p. 47.
[53] Australian Institute of Health and Welfare, 'Health impacts of family, domestic and sexual violence,' 2020, AIHW, Canberra, viewed 12 December 2021 <https://www.aihw.gov.au/reports/australias-health/health-impacts-family-domestic-and-sexual-violence>.
[54] Australian Institute of Health and Welfare, 'Health impacts of family, domestic and sexual violence,' AIHW, Canberra, 2020, viewed 12 December 2021 <https://www.aihw.gov.au/reports/australias-health/health-impacts-family-domestic-and-sexual-violence>.

The 2018 ABDS identified that 'intimate partner violence contributed to 1.4% of the total disease burden in Australian women,' and contributed to 19 per cent of the burden due to suicide and self-inflicted injuries:

> Total burden due to intimate partner violence was highest for women between ages 35–44 years. The most burden due to intimate partner violence in this age group was from depressive disorders, anxiety disorders, and suicide & self-inflicted injuries.[55]

Work by the Australian National Research Organisation for Women's Safety (**ANROWS**) has further identified that 'there is a gap in the burden between Indigenous and non-Indigenous women,' noting that 'among Indigenous women aged 18-44 years', rates of burden due to intimate partner violence 'are 6.3 times higher than for non-Indigenous women in the same age group.' For suicide and self-inflicted injuries, estimated rates of burden due to intimate partner violence are seven times higher 'among Indigenous women aged 18-44 years than non-Indigenous women of the same age.'[56]

In this context, qualitative Australian research has demonstrated the significant health impacts of intimate partner violence, and causally linked exposure to intimate partner violence with the burden of suicide and self-harm among Australian women.

1.2.5 Aboriginal and/or Torres Strait Islander researchers identify that family violence and suicide are connected

In defining and examining the nature of family violence, Aboriginal and/or Torres Strait Islander people have highlighted the connection between family violence and suicide.

In Victoria, the Victorian Indigenous Family Violence Task Force's definition of family violence 'extends to one-on one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide,'[57] and further notes:

> The Task Force recognises the importance of providing a nurturing environment for Indigenous children and young people. Task Force members know from personal experience that some young Indigenous people may commit suicide to end their lives and be rid of family violence issues.[58]

The research literature identifies that 'family violence impairs the protective connections between family and kin. It drives the transmission of trauma across generations and has been linked to a range of adverse life outcomes, mental health challenges, as well as suicide and suicide-related behaviour.'[59] Researchers also identify that family violence 'disrupts healthy connections to family and has long-term negative impacts on mental health and wellbeing of children and their mothers,' and 'makes children more vulnerable to suicide and suicide-related behaviour.'[60]

[55] Australian Institute of Health and Welfare, 'Australian Burden of Disease Study 2018: Interactive data on risk factor burden,' 2021, viewed 13 December 2021 <https://www.aihw.gov.au/getmedia/5664eeb9-eb36-4db9-a86c-28398228296d/ABDS-2018-Interactive-data-on-risk-factor-burden.pdf.aspx?inline=true>.
[56] Webster K, *A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions,* 2016, ANROWS, Sydney, p. 4.
[57] Victorian Indigenous Family Violence Task Force, *Victorian Indigenous Family Violence Task Force Final Report*, 2003, Victorian Government, Melbourne, p. 123.
[58] Victorian Indigenous Family Violence Task Force, *Victorian Indigenous Family Violence Task Force Final Report*, 2003, Victorian Government, Melbourne, p. 167.
[59] Dudgeon P, Blustein S, Bray A et al, *Connection between family, kinship and social and emotional wellbeing*, 2021, Mental Health and Suicide Prevention Clearinghouse, Australian Institute of Health and Welfare, Canberra, p. 15.
[60] Dudgeon P, Blustein S, Bray A et al, *Connection between family, kinship and social and emotional wellbeing*, 2021, Mental Health and Suicide Prevention Clearinghouse, Australian Institute of Health and Welfare, Canberra, p. v.

In 2020, the Australian Human Rights Commission released the *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report* (**the Wiyi Yani U Thangani Report**), the result of a project to elevate the voices of Aboriginal and/or Torres Strait Islander women and girls. The Wiyi Yani U Thangani Report highlighted that:

> The disproportionate rate of suicide in Aboriginal and Torres Strait Islander populations is in part attributed to higher levels of social and economic disadvantage, and increased exposure to known risk factors shared with the general population such as poverty, unemployment, homelessness, incarceration and family violence.[61]

[61] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Canberra, p. 433.

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2 Understanding the impact of family and domestic violence on women

2.1 Family and domestic violence is gendered violence and criminal behaviour perpetrated against women and children

Family and domestic violence is a violent crime perpetrated by men against women and children that 'tears lives apart.'[62]

Each week in Australia, on average, one woman is killed by her current or former partner.[63] In contrast, men are most likely to experience violence in public from a stranger.[64]

Women are most likely to experience violence from someone they know (often a current or a previous partner) in their own home:

> **One in three** women has experienced:
>
> - Physical violence perpetrated by another person, irrespective of the type of relationship (30.5%. ABS, 2017).
>
> - Physical or sexual violence, or both, perpetrated by a man they know (31.1%. ABS, 2017). [original emphasis][65]

It is important to observe that the statistic of 'one in three' is reported experience; actual experience is likely to be much higher, given levels of underreporting identified in the literature.[66]

It is also important to recognise the 'individual stories of courage, hope and resilience that form the backdrop of these statistics.'[67]

[62] NSW Government Communities and Justice, *The effects of domestic and family violence*, September 2019, viewed 18 February 2022, <https://www.facs.nsw.gov.au/domestic-violence/about/effects-of-dv>.
[63] Australia's National Research Organisation for Women's Safety, Violence *against women: Accurate use of key statistics (ANROWS Insights 05/2018)*, 2018, ANROWS, Sydney; Cussen T & Bryant W, *Domestic/family homicide in Australia (Research in practice, no. 38),* 2015, Australian Institute of Criminology; Bryant W & Bricknell S, *Homicide in Australia 2012-13 and 2013-14: National Homicide Monitoring Program report*, 2017, Australian Institute of Criminology, Canberra.
[64] Australian Institute of Health and Welfare, *Family, domestic, and sexual violence in Australia, 2018*, AIHW, February 2018, viewed 18 February 2022, <https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/summary>.
[65] Australia's National Research Organisation for Women's Safety, *Violence against women: Accurate use of key statistics (ANROWS Insights 05/2018),* 2018, ANROWS.
[66] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3, AIHW, Canberra.
[67] Australia's National Research Organisation for Women's Safety, *Violence against women: Accurate use of key statistics (ANROWS Insights 05/2018),* 2018, ANROWS.

The National Plan to Reduce Violence Against Women and their Children 2010-2022 states that:

> While a small proportion of men are victims of domestic violence and sexual assault, the majority of people who experience this kind of violence are women – in a home, at the hands of men they know.[68]
>
> Family and domestic violence is a violent crime that pervades the whole of society. [Family and domestic violence] is not limited to one section of society; it is not based on socio-economic circumstance, race, religion or creed.'[69]

Figure 1: Gendered patterns in violence perpetration and victimisation

Sources: Our Watch, Australian Bureau of Statistics, Australian Human Rights Commission, Australian Institute of Criminology, Australian Institute of Health and Welfare

[68] Council of Australian Governments, *National Plan to Reduce Violence against Women and their Children 2010 – 2022*, 2011, viewed 18 September 2020, <http://www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children>.

[69] Community Development and Justice Standing Committee, *Opening Doors to Justice: Supporting victims by improving the management of family and domestic violence matters in the Magistrates Court of Western Australia*, 2020, Legislative Assembly, Parliament of Western Australia, Perth, p. 15.

Recognising the gendered nature of family and domestic violence and its relationship with historic and current systemic misogyny and sexism and the structural social, political and economic inequality of women (and the role of men in causing and perpetrating this inequality) is an essential, indeed inseparable, element for ensuring successful service systems, policies and responses to family and domestic violence.[70] Without such recognition, responses to family and domestic violence may fail to realise their objectives and result in 'unintended consequences for women', such as:

- providing an additional avenue for abuse by a perpetrator of family and domestic violence by exacerbating the power differentials within intimate and family relationships;[71]
- introducing additional barriers for women seeking to leave a violent situation;
- inappropriate confrontation and interventions involving a perpetrator that may increase risk for victims;[72] and
- re-traumatising victims, for example through the removal of children from their care or requiring women to visit multiple agencies a number of times to access supports to promote their safety.[73]

2.2 Family and domestic violence includes non-physical, coercive controlling behaviours

2.2.1 The United Nations' definition of violence against women

The United Nations *Declaration on the Elimination of Violence against Women* states that:

> Violence against women is any act of gender-based violence that causes or could cause physical, sexual or psychological harm or suffering to women, including threats of harm or coercion, in public or in private life.[74]

In 2017, the UN Committee for the Elimination of Discrimination against Women adopted Recommendation No. 35 on gender-based violence against women, which defines 'gender-based violence against women' as encompassing all forms of violence, harassment, abuse and coercive control that women experience across their lifespan, (including girls and young women), that:

> … takes multiple forms, including acts or omissions intended or likely to cause or result in death or physical, sexual, psychological, or economic harm or suffering to women, threats of such acts, harassment, coercion, and arbitrary deprivation of liberty. …

[70] Poon J, Dawson M & Morton M, 'Factors increasing the likelihood of sole and dual charging of women for intimate partner violence', *Violence Against Women*, 2014, 20(12), 1447–1472; Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law* (Research report, 23/2020), 2020, ANROWS; Nancarrow H, *Unintended consequences of domestic violence law: Gendered aspirations and racialised realities*, 2019, Springer Nature.
[71] Douglas H and Chapple K, *National domestic and family violence bench book*, 2019, viewed 18 February 2022, <http://dfvbenchbook.aija.org.au/>.
[72] Victorian Government, *MARAM victim survivor practice guide - Responsibility 1: Respectful, sensitive and safe engagement, Section 1.3.2: Physical environmen*t, 4 October 2021, viewed 18 February 2022, <https://www.vic.gov.au/maram-practice-guides-and-resources/responsibility-1>.
[73] Carne S, Rees D, Paton N & Fanslow J, *Using Systems Thinking to Address Intimate Partner Violence and Child Abuse in New Zealand*, 2019, New Zealand Family Violence Clearinghouse, University of Auckland; Hamby S & Grych J, *The Web of Violence: Exploring Connections Among Different Forms of Interpersonal Violence and Abuse*, 2013, Springer, Dordrecht, NY; Dale A, 'Systemic abuse: the devastating ripple effects of family violence', *Law Society Journal*, 2 July 2019, viewed 18 February 2022, <https://lsj.com.au/articles/systemic-abuse-the-ripple-effects-of-family-violence/>.
[74] United Nations General Assembly, *Declaration on the Elimination of Violence against Women* (1993), viewed 18 February 2022, <https://digitallibrary.un.org/record/179739?ln=en>.

> The Committee regards gender-based violence against women to be rooted in gender-related factors such as the ideology of men's entitlement and privilege over women, social norms regarding masculinity, the need to assert male control or power, enforce gender roles, or prevent, discourage or punish what is considered to be unacceptable female behaviour. These factors also contribute to the explicit or implicit social acceptance of gender-based violence against women, often still considered as a private matter, and to the widespread impunity for it.
>
> Gender-based violence against women occurs in all spaces and spheres of human interaction, whether public or private. These include the family, the community, the public spaces, the workplace, leisure, politics, sport, health services, educational settings and their redefinition through technology-mediated environments, such as contemporary forms of violence occurring in the Internet and digital spaces.[75]

2.2.2 Australian definitions of family and domestic violence

Across Australia, there is 'no single nationally or internationally agreed definition' of family and domestic violence, and the set of behaviours captured by the term 'varies across the policy, legislative, service provision, and research contexts.'[76]

The Australian Institute of Health and Welfare identifies that family and domestic violence includes acts and behaviours of varying 'type, intensity and frequency' where a perpetrator exercises power and control over their partner or family member using physical violence, sexual violence, and/or psychological and emotional abuse:

> **Physical violence** can include slaps, hits, punches, being pushed downstairs or across a room, choking and burns, as well as the use of knives, firearms and other weapons.
>
> **Sexual violence** can include rape; sexual abuse; unwanted sexual advances or harassment and intimidation at work and elsewhere; being forced to watch or engage in pornography; sexual coercion; having sexual intercourse because you are afraid of what your partner might do; forced prostitution; and trafficking.
>
> **Psychological and emotional abuse** can include intimidation, belittling, humiliation, coercive control and the effects of financial, social and other non-physical forms of abuse.
>
> The types of violence described here are not an exhaustive list of all possible acts and behaviours that can be classified under the umbrella term of 'family, domestic and sexual violence'. The term 'violence' also includes the attempt or threat of violence.[77]

[75] United Nations Committee on the Elimination of Discrimination against Women, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, 14 July 2017 CEDAW/C/GC/35.
[76] Australian Bureau of Statistics, 'Defining Family and Domestic Violence', *Directory of Family and Domestic Violence Statistics*, 2018, cat. no. 4533.0, ABS, Canberra.
[77] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, Australian Government, Canberra, p. 2.

2.2.3 Western Australian definition of family and domestic violence

In using the term 'family and domestic violence', the Office refers to the relationships and behaviours specified in the *Restraining Orders Act 1997* (**the Restraining Orders Act**).

Section 5A of the *Restraining Orders Act* recognises a range of violent, threatening, coercive, controlling and fear-inducing behaviours beyond physical abuse as 'family violence', including sexual, emotional, psychological and financial abuse, as follows:

> (1) A reference in this Act to ***family violence*** is a reference to —
>
> (a) violence, or a threat of violence, by a person towards a family member of the person; or
> (b) any other behaviour by the person that coerces or controls the family member or causes the member to be fearful.
>
> (2) Examples of behaviour that may constitute family violence include (but are not limited to) the following —
>
> (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 dependant 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 an intimate image of the family member without the family member's consent, or threatening to distribute the image;
> (l) causing any family member who is a child to be exposed to behaviour referred to in this section.[78]

The *Restraining Orders Act* also defines 'family relationship' and 'family member' broadly, to include current and former:

- spouses, de-facto partners, siblings, children, parents, grandparents, step-parents;
- biological and extended relatives recognised in a person's cultural, social or religious background;
- members within other intimate and other family-like personal relationships; and
- former spouses and de-facto partners of a person's current partner.

[78] *Restraining Orders Act 1997* (WA), s. 5A(2)-(3).

Section 4 of *the Restraining Orders Act* provides the following definitions of 'family relationship' and 'family member':

(1) In this Act —

family relationship means a relationship between 2 persons —

(a) who are, or were, married to each other; or
(b) who are, or were, in a de facto relationship with each other; or
(c) who are, or were, related to each other; or
(d) one of whom is a child who —
    (i) ordinarily resides, or resided, with the other person; or
    (ii) regularly resides or stays, or resided or stayed, with the other person; or
(e) one of whom is, or was, a child of whom the other person is a guardian; or
(f) who have, or had, an intimate personal relationship, or other personal relationship, with each other; or
(g) one of whom is the former spouse or former de facto partner of the other person's current spouse or current de facto partner.

(2) In subsection (1) —

other personal relationship means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected, the other person;

related, in relation to a person, means a person who —

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

(3) In this Act a person is a family member of another person if the persons are in a family relationship.

2.2.4 Coercive control

Family and domestic violence is not solely made up of discrete, isolated incidents of violence.[79] Power and control are central to understanding family and domestic violence. These concepts are 'well understood by those who have experienced it' and have been expressed in recent research literature using the concept of 'coercive control.'[80]

Coercive control is the relentless pattern of behaviour and 'tactics to isolate, degrade, exploit … frighten or hurt [victims] physically' specifically targeting and responding to a victim-survivor, with the aim of controlling their life.[81]

[79] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 93.
[80] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law* (Research report, 23/2020), 2020, ANROWS, p. 47.
[81] Stark E, 'Re-representing Battered Women: Coercive Control and the Defense of Liberty,' prepared for Violence Against Women Complex Realities and New Issues in a Changing World Conference, Montreal, 2012, viewed 9 October 2020 <http://www.stopvaw.org/uploads/evan_stark_article_final_100812.pdf>.

Coercive control is ongoing, insidious, and 'almost exclusively perpetrated by men against women.' [82] Coercive controlling behaviours are 'not simply an action within a list of other actions that may constitute DFV [domestic and family violence], but is the *context* in which DFV occurs.'[83]

Controlling behaviour develops gradually, 'often creep[ing] unnoticed into a relationship:'

> The majority of women said that at the beginning, they loved their partner. Many referred to him as their **'Prince Charming'**. Initially their partner's behaviour could be seen as loving, for example wanting to spend all their time together, but gradually their partner became more controlling. Women said they found it difficult to put their finger on exactly what was wrong, as the individual actions themselves could be part of any 'normal' relationship, or even trivial. For example, Jessica was criticised for **'not cutting the cheese straight'**. Sara's partner kept telling her a dishwasher would not fit in the kitchen even though she presented the measurements that showed it would. Over time, however, these comments formed a pattern of increasing control. Women described their behaviour, activities and access to friends and family being increasingly controlled so that their life revolved more and more around their partner.
>
> Women described how their partner would 'punish' them and threaten more serious harm to her or the children if they did not do as they wanted. Charlotte and Nessa both described how their partners became more and more controlling, cutting off their access to friends by withholding money for phone credit. Charlotte felt herself **'slowly shutting down… disappearing'**.[84] [original emphasis]

In the Australian context, media reporting of the circumstances prior to the death of Hannah Clarke in Queensland during 2020 illustrates the mixture of abusive behaviours that can be used to target and control a person by perpetrators of family and domestic violence:

> [Media reporting] … revealed a significant pattern of control and coercion, in which the perpetrator used recording devices to monitor Hannah's conversations, controlled what she wore (for example by preventing her from wearing shorts or a bikini off the beach), and isolated her from her family. Reporting also noted that this was coupled with sexual violence, in which [Rowan] Baxter forced Hannah to have sex with him every night, and made threats if she did not comply. Even when they separated, Baxter continued to track and monitor Hannah's actions and movements, and sought to control her through their children, including kidnapping one of them, which he claimed was punishment for her leaving him.[85]

[82] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 40.
[83] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 2.
[84] Healthtalk, *Women's experiences of Domestic Violence and Abuse: Coercive Controlling Behaviour*, February 2020, viewed 18 February 2022 <https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/emotional-psychological-abuse-and-effects-on-womens-self-esteem>.
[85] NSW Government, *Coercive Control: Discussion Paper*, October 2020, p. 7-8, viewed 18 February 2020 <http://www.crimeprevention.nsw.gov.au/domesticviolence/Documents/domestic-violence/discussion-paper-coercive-control.pdf>.

The Queensland Domestic and Family Violence Death Review and Advisory Board has repeatedly observed a number of coercive controlling behaviours in its reports, including:

Emotional, verbal and psychological abuse

- mocking and humiliating victims including insults, name calling, derogatory put downs, constant criticisms, and belittling.
- systems abuse (e.g. using legal mechanisms to portray the victim in a negative manner or as the abuser).
- gaslighting (e.g. by confusing victims and making them question their memory of events).
- threatening suicide and/or self-harm.
- yelling and screaming.
- isolation and intimidation.
- trying to stop victims from having contact with friends, family and support systems (e.g. threatening to harm other people the victim may have contact with, constant accusations of infidelity and expressing jealousy and suspicion of friends and family).
- threats to harm or kill the victim, children and pets.
- threats to take children away.
- monitoring victims through online communication tools, spyware, or physically stalking them.
- making victims account for their whereabouts at all times.
- depriving victims of their basic needs (e.g. access to transport, food, finances and medical care).
- damaging victims' property or removing their access to property.
- deprivation of liberty or autonomy (e.g. preventing victims from leaving their house or restricting their movements beyond the household).
- attempting to control victims through fear and intimidation.
- neglecting children to control victims.
- using weapons to threaten victims.

Financial abuse

- stealing victims' money or belongings/borrowing money and refusing to give it back.
- refusing to contribute to shared costs/making the victim pay for everything.
- controlling victims' finances and expenditure.
- restricting victims' access to bank accounts/credit cards/financial information.
- preventing victims from obtaining employment.

Physical abuse

- non-lethal strangulation.
- assaulting victims through punching, kicking, shoving, grabbing, slapping.
- assaulting victims with weapons (e.g. knives, bats and household objects).

Sexual abuse

- rape and sexual assault.
- pressuring victims to have sex or perform sexual acts through threats and intimidation.
- making degrading sexual comments.[86]

Coercive control is also a predictor of severe physical violence and homicide.[87]

[86] Queensland Domestic and Family Violence Death Review and Advisory Board, *Annual Report 2020-21*, 2021, p. 53-54.
[87] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 20.

2.3 Family and domestic violence can have devastating effects

Each and every woman that experiences family and domestic violence has a unique and individual experience, and 'the individual and cumulative impact of each act of violence depends on many complex factors.'[88] As noted earlier, the complexity and reality of women's experiences of family and domestic violence cannot be accurately and completely accounted for by aggregate data and 'it is important to recognise the individual stories of courage, hope and resilience that form the backdrop of these statistics.'[89]

Family and domestic violence seriously affects women's health and causes more illness, disability and deaths than any other risk factor for women aged 25–44, including smoking, alcohol and obesity.[90] The health impacts of family and domestic violence include 'injuries and homicide, poor mental health, reproductive health problems and problems with alcohol and drug use.'[91]

Violence against women and children can also significantly impact on their short and long-term health, wellbeing, education, relationships and housing outcomes.[92]

Communities, governments and businesses also suffer the effects of family and domestic violence, with the estimated total annual cost of this violence in Australia during 2015-16 being $22 billion.[93]

Coercive control is 'commonly described by victim-survivors as the worst form of abuse they experience' that can be 'hostage-like' in the harmful way it erodes a person's safety, wellbeing, confidence, self-esteem, 'autonomy and personhood, as well as to physical and psychological integrity.'[94] These effects have been described as 'intimate terrorism', leaving 'emotional and psychological scars [that] are not immediately visible':[95]

> Constantly having to deal with the changing demands of an abusive partner wears women down, so that they develop a range of problems such as finding it difficult to sleep and eat and symptoms of anxiety, self-harming and suicide attempts.[96]

[88] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3, AIHW, Canberra.
[89] Australia's National Research Organisation for Women's Safety, *Violence against women: Accurate use of key statistics (ANROWS Insights 05/2018),* 2018, ANROWS, p.1.
[90] Ayre J, Lum On M, Webster K, Gourley M, & Moon L, *Examination of the burden of disease of intimate partner violence against women in 2011: Final report*, 2016, ANROWS, p. 9.
[91] Webster K, *A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions,* 2016, ANROWS, Sydney, p. 4.
[92] Ayre J, Lum On M, Webster K, Gourley M, & Moon L, *Examination of the burden of disease of intimate partner violence against women in 2011: Final report*, 2016, ANROWS, p. 9.
[93] KPMG, *The cost of violence against women and their children in Australia: Final detailed report*, 2016, Sydney, NSW.
[94] Parliament of Australia, House of Representatives Standing Committee on Social Policy and Legal Affairs, *Final Report: Inquiry into family, domestic and sexual violence*, March 2021, p. 11 <https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Report/section?id=committees%2Freportrep%2F024577%2F75463>.
[95] Healthtalk, *Women's experiences of Domestic Violence and Abuse: Emotional-psychological abuse and effects on women's self-esteem*, February 2020, viewed 18 February 2022 <https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/emotional-psychological-abuse-and-effects-on-womens-self-esteem>.
[96] Healthtalk, *Women's experiences of Domestic Violence and Abuse: Emotional-psychological abuse and effects on women's self-esteem*, February 2020, viewed 18 February 2022 <https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/emotional-psychological-abuse-and-effects-on-womens-self-esteem>.

Research which has followed survivors over time after separation, has shown that the emotional impacts of coercive controlling behaviours within an intimate partnership can persist over the long-term and include:

- feelings of shock and grief after recognising abuse;
- ongoing feelings of anger and/or regret;
- loss of trust;
- feeling powerless; and
- losing a sense of identity.[97]

Women who have experienced after-effects from coercive controlling behaviours describe feelings of loss, isolation, hopelessness, self-loathing and anger:

> We know from the testimonies of women over past decades that, for many, emotional-psychological abuse was often more damaging than physical abuse. … Women described how their partners would stop them from seeing family and friends, constantly criticise their behaviour or appearance and punish them if they failed to meet their demands. By isolating women through emotional and psychological abuse, partners' control often increased. …
>
> 'I'm more angry with me than I am with him. … And I hate myself more than I do him, because I've got no emotion …. I don't hate him, I'm not angry at him, I don't think anything of him because I cannot be bothered to give him any emotion.' …
>
> 'The self-loathing and the self-hate is probably still with me today and I don't know truly how long the mental side will take to heal. …the bruises and everything else, they heal, they go. The mental side, it's stopped me going into any other relationship because I can't. I've got a real trust issue so I can't.' …
>
> Melanie described feeling like she was 'nothing' and being powerless to change anything. Many also suffered from depression alongside the lack of confidence and as Penny explained, that made it more difficult to leave:
>
> 'I just felt - well my confidence, confidence just went down and down and down and I was so depressed really that I wasn't in a state to get out of it.' …
>
> Women used words like feeling **'only half the woman I was before'**, that their **'light had gone out'**. Often they said that, rather than being themselves they tried to become the person their partner wanted them to be.[98]

Neuroimaging studies on trauma and the processing of intense emotions have also identified that experiencing abuse causes physical changes in the brain, 'that are believed to be responsible for physical and psychological symptoms associated with complex trauma, such as difficulties in regulating emotional and physiological states and communicating experiences in therapeutic settings.'[99]

[97] Healthtalk, *Women's experiences of Domestic Violence and Abuse: Emotional-psychological abuse and effects on women's self-esteem*, February 2020, viewed 18 February 2022 <https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/emotional-psychological-abuse-and-effects-on-womens-self-esteem>.
[98] Healthtalk, *Women's experiences of Domestic Violence and Abuse: Emotional-psychological abuse and effects on women's self-esteem*, February 2020, viewed 18 February 2022 <https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/emotional-psychological-abuse-and-effects-on-womens-self-esteem>.
[99] Australian Government, *Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report, Volume 9: Advocacy, support and therapeutic treatment services*, 2017, Commonwealth of Australia, p. 57; van der Kolk BA, 'Clinical implications of neuroscience research in PTSD', *Annals of the New York Academy of Sciences*, 2006, 1071(1), p. 278.

Some victim behaviours often viewed as 'difficult', 'uncooperative' or 'non-engagement' by services providers may arise from the cumulative impact of these changes to brain structure and function over time: For example, permanent damage to memory systems like the hippocampus can impact on a person's recall of events and give the story a fragmented appearance. This is not deliberate but a function of brain development, which can make the taking of a statement very frustrating particularly in cases of repeated trauma where specific detail may be lost. Trauma can affect a child's brain functioning, mental and physical health, schooling and sexual behaviour, and the child may need support in all these areas.[100]

2.4 Some women and children are more vulnerable to family and domestic violence

As noted by the AIHW:

> Understanding how family, domestic and sexual violence is experienced by different population groups helps to inform and support the development of appropriate services, education and prevention programs. The ways in which different people experience family, domestic and sexual violence, and the options they have to access services that meet their needs, can be shaped by multiple intersecting cultural, social and physical factors.[101]

Aboriginal and Torres Strait Islander women, young women, pregnant women, women separating from their partners, women with disability, older women, women from culturally and linguistically diverse backgrounds, LGBTIQ+ people; women living in rural and remote areas, and women experiencing socioeconomically disadvantage and women financial hardship are at greater risk of family, domestic and sexual violence.[102]

Children and Aboriginal and Torres Strait Islander women are particularly vulnerable to family and domestic violence in Western Australia, and for this reason are the subject of separate consideration, where relevant, in this investigation.

2.5 Perpetrators deliberately choose to use violence and may use legal and support services to maintain control or inflect abuse

The research literature suggests that perpetrators of family and domestic violence will take steps to avoid being held accountable for their behaviour, including instances where perpetrators may present the violence as mutual or joint, both to avoid responsibility and to shift responsibility to the victim.[103] This includes where perpetrators describe violence as an 'argument' or 'retaliation' or allege that that a victim is an unfit or incapable parent.[104]

[100] Hart H & Rubia K, 'Neuroimaging of child abuse: A critical review', *Frontiers in Human Neuroscience*,2012, 6(52); MH Teicher & JA Samson, 'Annual research review: Enduring neurobiological effects of childhood abuse and neglect', *The Journal of Child Psychology and Psychiatry*, 2016, 57(3); Child Welfare Information Gateway, *Understanding the effects of maltreatment on brain development, Children's Bureau*, Washington DC, 2015.
Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3, AIHW, Canberra, p. 70.
[102] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3, AIHW, Canberra, p. 70.
[103] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, Perth, p. 12.
[104] Chung, D, Green, D and Smith G et al, *Breaching Safety: Improving the Effectiveness of Violence Restraining Orders for Victims of Family and Domestic Violence*, 2014, The Women's Council for Domestic and Family Violence Services, Perth, p. 11.

Examples of strategies used by perpetrators to manipulate institutions and maintain control over a victim include:

- Threatening to call Child Protective Services … and making actual reports that his partner neglects or abuses the children.
- Changing lawyers and delaying court hearings to increase his partner's financial hardship.
- Telling police officers she hit him, too.
- Giving false information about the criminal justice system to confuse his partner or prevent her from acting on her own behalf.[105]

The Department of Communities identifies that collusive child protection practice entails significant risk of endangering women and children's safety, observing that:

> Men who perpetrate violence can be persuasive and subtle in the ways they downplay, deny, justify and rationalise their behaviour. Furthermore, they hold implicit beliefs—about women, relating to women and relationships—that enable them to feel right and vindicated regarding their behaviours and to perceive themselves as the victim in their interpersonal relationships.
>
> When you are trying to engage a perpetrator of family and domestic violence, it is very likely that he will try to get you to collude with his narrative about the violence, perhaps by:
>
> - presenting as calm, collected and reasonable;
> - presenting his (ex)partner as irrational, unreasonable or mentally ill;
> - lying about or omitting known facts, or presenting a partial picture;
> - claiming his partner is lying or fabricating evidence;
> - claiming 'the system' is out to get him;
> - speaking on behalf of his (ex)partner—especially if he is her carer;
> - claiming the violence is mutual;
> - acknowledging some wrongs while not accepting responsibility; or
> - attempting to use humour or other forms of charm to win you over.
>
> … If you collude, you might reinforce the perpetrator's violence-supporting narratives, at considerable cost to his family members.[106]

As identified in the Ombudsman's 2015 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, it is critically important that all State government departments and authorities working with women and child victims of family and domestic violence are aware of the risk of being manipulated by perpetrators.

[105] Alabama Coalition Against Domestic Violence, *Why do Abusers Batter?*, Alabama Coalition Against Domestic Violence, 2015, as quoted by Ombudsman Western Australia *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, Ombudsman Western Australia, Perth, 2015, p. 129.
[106] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, p. 47-48.

2.6 Victims of family and domestic violence will resist violence perpetrated against them and try to protect themselves and their children

The research literature identifies that victims of family and domestic violence will consider and use a wide array of strategies to resist and respond to violence, and that the way in which victims respond to and resist violence depends upon the dangers and opportunities of their specific circumstances.[107]

Victims may resist violence utilising both covert and overt strategies.[108] Overt resistance strategies used by victims can include openly challenging the perpetrator's behaviour; 'accessing formal and/or informal help' and/or separating from the perpetrator, which can involve 'a range of autonomous behaviors that directly challenge [sic]' a partner's control.[109] Covert resistance involves taking action without the perpetrator knowing about it, such as 'storing away personal objects or thinking about something else during an abusive incident'.[110] In this context, the research literature observes that 'victims are acutely aware that any defiant acts will be matched by an increase in the perpetrator's violence,' and that 'agency and service records serve as a testament that victims' acts of resistance are generally overlooked and unrecognised.[111]

Victims may not present to services in the submissive, passive and cooperative ways often depicted in popular culture and stereotypically gendered stereotypes about women's responses to violence.[112] More often, victims will have 'extremely varied responses' to individual incidents of violent behaviour, including:

> … being unwilling to talk to the police (or leaving the scene); appearing to be "emotional", angry, aggressive or unafraid; being confused or unable to convey a "straight" account or story; or expressing a desire to not act against, or leave, the other person.[113]

Women may also make use of household items in self-defence in retaliation against a male perpetrator and or be under the influence of alcohol or other substances.[114]

[107] For example, Wilson, D, Smith, R, Tolmie, J and de Haan, I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, p. 28.
[108] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 3.
[109] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 5.
[110] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 3.
[111] Wilson, D, Smith, R, Tolmie, J and de Haan, I, *Becoming Better Helpers rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, New Zealand, p. 27-28.
[112] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS,, p. 2.
[113] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 2.
[114] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 26.

Researchers in the area of family and domestic violence further identify that some strategies employed by victims may create the perception that a victim is also a perpetrator of violence or not responding in a way that may align with expectations, such as 'fighting back or defying the [perpetrator],' or using or abusing substances as an 'escape' or to numb physical pain.[115]

> Although these protective strategies act as coping and survival mechanisms for victims, they are frequently misinterpreted by laypersons and professionals who view the victim's behavior as uncooperative, ineffective, or neglectful.[116]

Researchers identify that for some victims 'use of force is 'not always defensive … often it is more aptly described as "violent resistance"', insofar as some women will respond to a violent partner with violence to stop or reduce the violence, or through 'anger, frustration or retaliation.'[117]

In resisting and responding to violence with the use of force, or in demonstrating behaviour that is likely to 'challenge our culture's dominant 'real' victim stereotype,'[118] the actions of some victims are not seen in the context of broader violence:

> Significantly … victims of family violence might engage in defensive or retaliatory behaviours as a response to violence. Where police use an incident-specific lens and do not see the context of the violence, this may erode the legitimacy of a woman's [or victim's] 'victimhood'.[119]

Researchers identify that these factors influence police decision making.[120] In 2010, the Australian Law Reform Commission observed that, if police 'fail to identify the "primary aggressor" and the "primary victim" when attending a scene of family violence,' 'this may mean that victims are wrongly charged with family-violence related offences and inappropriately having protection orders taken out against them,'[121] with a Western Australian stakeholder identifying:

> The view put forward by the Western Australia Police is that, although understanding the nature of domestic violence is crucial to ensuring an effective response, ultimately members are only able to respond to the circumstances before them. In ambiguous circumstances, an understanding of who is likely to be the primary aggressor will be a useful guide. However, if the female is the one who clearly appears to be threatening to commit an act of family and domestic violence, the police are obliged to respond to the circumstance before them. According to police, this means that, just as it is not the role of police to take into consideration

[115] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 28.
[116] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 29.
[117] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[118] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[119] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 4.
[120] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[121] Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, Australian Government, Canberra, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.

> circumstances that may amount to a defence when considering whether to arrest for the commission of an offence, police are obliged to issue an order against the woman notwithstanding that she may have been subjected to acts of domestic violence many times in the past. [122]

The research literature consistently identifies that victims of family and domestic violence will resist violence perpetrated against them and try to protect themselves and their children, and/or seek help.[123] At times, victims' decisions about how they resist violence and attempt to protect themselves does not align with the expectations of outsiders or state government departments and authorities. This does not negate their experiences as victims of family and domestic violence, and does not mean that victims do not need, want, or are less deserving of, help.

2.7 Women are misidentified as a perpetrator of family and domestic violence

In Australia, each State and Territory has introduced laws attempting to address the harmful effects of family and domestic violence on women and to enable them to seek protection from harm occurring in the future.[124]

> When police are called to an incident of DFV, one of their tasks under civil DFV law is to determine whether a party is in need of protection from future violence. However, it is not easy in the moment for police to determine if the violence they have been called to attend to is violence that has been used in response to DFV.[125]

The difficulty experienced by police in determining who is the 'person most in need of protection' when attending call outs relating to family and domestic violence, can lead to misidentification of 'women who use violence in response to abuse' as suspected perpetrators of abuse, particularly when there are 'mutual allegations of violence.'[126]

There are many factors that contribute to the misidentification of women as perpetrators of family and domestic violence, including:

> … misperceptions of victim behaviour, perpetrator manipulation of police and legal systems, and incident-based policing in a civil law context that requires investigation of a pattern of coercive control.[127]

[122] Centacare Safer Families Support Service, quoted by Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, Australian Government, Canberra, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[123] For example, For example, Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington; Burstow B, *Radical Feminist Therapy*, 1992, Sage Publications, Newbury Park, California; Kelly L, *Surviving Sexual Violence*, 1988, University of Minnesota Press, Minneapolis.
[124] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS.
[125] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS.
[126] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS.
[127] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p.34.

Additionally, misidentification of women as perpetrators may arise as a result of 'system abuse' which occurs when:

> … the actual perpetrator uses legal processes as a tactic of further control and abuse. This can happen at multiple points of contact with police and courts, including applications for protection orders in retaliation, and to make false allegations of DFV in family law matters. It can also be a perpetrator tactic to pressure withdrawal of the victim's/survivor's legitimate protection order and escape accountability, or a strategy to deplete the victim's/survivor's financial and emotional resources.
>
> The QDFVDR&AB found several of the DFV-related deaths reviewed included evidence of men calling the police "as a pre-emptive strike against their aggrieved partner particularly where cross protection orders are in place … including the perpetrator threatening to report false allegations against the victim to police in an attempt to get her in trouble" (2017, p. 83).
>
> Other studies have found evidence of perpetrators claiming that female victims were the primary aggressors by minimising their role in the incident, injuring themselves, calling the police first, and projecting a calm appearance when police attended the scene.[128]

The misidentification of women as perpetrators is echoed in applications for Restraining Orders in Western Australia and other protective orders in Australia, with a Queensland review of family and domestic violence related deaths finding that:

- in 44.4 per cent of female family and domestic violence related deaths reviewed, the woman who died had been identified as a respondent to a protective order at least once; and
- in nearly all cases where an Aboriginal person had died in circumstances of family and domestic violence, they had been recorded as both a respondent and applicant in protective proceedings prior to their death.[129]

Additionally, recent research by ANROWS has found that:

> … in most jurisdictions a significant minority (between one fifth and one quarter) of respondents on protection orders are female. Given what is known about the gendered nature of DFV and women's use of violence, this proportion of female respondents suggests a likelihood of victims/survivors being misidentified as perpetrators of DFV. In most jurisdictions, Aboriginal and Torres Strait Islander peoples are over-represented as respondents on DFV protection orders. They are also over-represented in charges for breaching DFV protection orders. This disproportionality is consistent with the literature on the over-representation of Aboriginal and Torres Strait Islander people in the legal system overall.[130]

Misidentification of women as perpetrators of violence has 'wide-ranging, harmful (even life-threatening) and long-term' impacts including re-victimisation of victims,

[128] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 30.
[129] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS.
[130] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS.

homelessness, criminal justice outcomes, and can undermine and compromise victim safety.[131]

2.8 Most family and domestic violence is not reported

As noted by the AIHW:

> It is difficult to accurately record the extent of family, domestic and sexual violence in the population. Incidents frequently occur behind closed doors and are often concealed by, and denied by, their perpetrators and sometimes by their victims. Data sources can only capture incidents that are disclosed by the individuals involved or recorded and/or reported to the relevant authorities.[132]

Most women who have experienced physical or sexual violence from a partner do not seek advice or support from the police (82 per cent), and many women are also reluctant to turn to informal networks of friends or family for support (46 per cent).[133] Accordingly, the numbers of women and children experiencing family and domestic violence are likely to be significantly higher than the number captured by administrative data, due to the general underreporting of this type of abuse, with the World Health Organization highlighting that:

> A large proportion of interpersonal violence is unreported to criminal justice agencies, often because individuals fear stigma (e.g. from family and friends) or retribution from abusers for revealing their abuse. … . In addition, many victims will not disclose their situation unless they are directly asked.[134]

Sexual violence within family and domestic violence relationships 'is one of the most under-reported tactics of DFV and is a significant indicator of escalating frequency and severity of DFV.'[135]

2.9 This investigation likely under-represents the relationship between family and domestic violence and suicide

Those examining the relationship between family and domestic violence and suicide highlight key challenges faced in undertaking this research, including gaps in data, changing data, the time taken to investigate and understand the circumstances of death and prior historical factors such as family and domestic violence, delays in the completion of coronial findings and determination of a cause of death, and delays in publicly reporting data or otherwise applying for and obtaining access to data.[136] One significant issue in undertaking this research is that data collected concerning family and domestic violence, and other key information about individuals who died by suicide, is retrospective:

> A primary challenge is that in a completed suicide the person best positioned to report on causal or other factors in relation to that suicide is deceased. In the absence of a suicide note, or in the absence of relevant service contacts, it can be

[131] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law* (Research report, 23/2020), 2020, ANROWS, p. 30-31.
[132] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story*, 2019, cat. no. FDV 3, AIHW, Canberra, p. 6.
[133] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: continuing the national story 2019—In brief*, 2019, cat. no. FDV 4, AIHW Canberra, p. ix.
[134] WHO, *Reducing violence through victim identification, care and support programmes,* (Series of briefings on violence prevention: the evidence), 2009, viewed 18 February 2022, <https://www.who.int/violence_injury_prevention/violence/programmes.pdf>.
[135] Australia's National Research Organisation for Women's Safety, *Accurately identifying the 'person most in need of protection' in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, p. 2.
[136] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017,* 2017, New South Wales Government, Sydney, p. 139.

> extremely difficult to ascertain what factors influenced the individuals' decision to end their life, or indeed what factors might have been decisive in that decision. This makes it difficult to conduct effective research examining causal factors and makes it difficult for researchers to draw firm conclusions around other aspects of the completed suicide.[137]

In conducting retrospective research, exposure to family and domestic violence can only be assessed based on reported evidence. As such, where available information details no evidence of family and domestic violence, this was interpreted to mean that an individual was not exposed to family and domestic violence.

As demonstrated by work undertaken in other jurisdictions, researchers have highlighted that this lack of data 'may have actually represented lack of reporting.' In Victoria, researchers highlighted that 'known underreporting of violence… may have resulted in underestimation of the incidence' of family and domestic violence.[138] Similarly, in establishing histories of violence for family and domestic violence homicides, Queensland's Domestic and Family Violence Death Review and Advisory Board has reported:

> It is also likely that this figure is an under-representation due to the well-established understanding that victims of domestic and family violence under-report their experiences to formal services.[139]

Due to the underreporting of family and domestic violence and the limitations of available information contained in the records of State government departments and authorities, this investigation also likely under-represents the extent of family and domestic violence among individuals who died by suicide.

[137] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017,* 2017, New South Wales Government, Sydney, p. 139.
[138] MacIsaac M, Bujega L, Weiland T et al, 'Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia,' *Asia Pacific Journal of Public Health,* 2018, 30(1), p. 42.
[139] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and Family Violence Death Review and Advisory Board 2018-2019 Annual Report*, 2019, Queensland Government, Brisbane, p. 32

3 Understanding the impact of family and domestic violence on children

3.1 Child safety is a paramount factor for child and adolescent health and wellbeing

As noted in the UN Convention on the rights of the child:

> Every child has the right to be alive. Governments must make sure that children survive and develop in the best possible way.[140]

Researchers identify that 'children are vulnerable to various forms of violence within their homes,'[141] and that 'the majority of violence takes place in the context of the families.'[142]

Eliminating and responding to violence against children is perhaps most challenging in the context of family, considered by most as the most "private" of private spheres. However, children's rights to life, survival, dignity and physical integrity do not stop at the door of the family home, nor do State's obligations to ensure these rights for children.[143]

Violence in the home has been identified as 'one of the most pervasive human rights challenges of our time.'[144] As noted by the Australian Government:

> Child abuse and neglect can have a life-changing effect on individuals, and many carry trauma with them for a long time, even their whole lives. While many survivors are able to rebuild their lives, there can be many hurdles to overcome. Children who are subjected to abuse or neglect may experience fear and bodily harm, poor school performance, learning disorders, poor peer relations, antisocial behaviour and mental health disorders. Emotional abuse and neglect is associated with increased anxiety, depression, post-traumatic stress, and physical symptoms, as well as lifetime trauma exposure. A history of child sexual abuse has been associated with psychopathology, depression, anxiety disorder, phobias, panic disorder, post-traumatic stress disorder, substance abuse and violent and sexual offending later in life. The intergenerational effects of child abuse and neglect mean that problems can repeat themselves, and the cycle continues. …
>
> Fundamentally, the abuse of children is a crime.[145]

The vast majority of those who experience violence, neglect or other abuse during childhood do not grow up into adults who perpetrate violence towards others.[146] In fact, 'a higher proportion of survivors of child abuse went on to experience domestic abuse in adulthood, compared with those who suffered no childhood abuse' according to analysis

[140] United Nations, *Convention on the Rights of the Child: The children's version*, Article 6, viewed 6 April 2020, <https://www.unicef.org/media/60981/file/convention-rights-child-text-child-friendly-version.pdf>.
[141] Paulo Sergio Pinheiro, *Report of the independent expert for the United Nations study on violence against children*, 2006, United Nations, New York, p. 13.
[142] United Nations Children's Fund, *General comment no. 13: the right of the child to freedom from all forms of violence*, 2011, Committee on the Rights of the Child, Geneva, p. 2.
[143] Paulo Sergio Pinheiro, *Report of the independent expert for the United Nations study on violence against children*, 2006, United Nations, New York, p. 12.
[144] United Nations Children's Fund, *Behind Closed Doors: The Impact of Domestic Violence on Children*, 2006, UNICEF, New York, p. 3.
[145] Department of Families, Housing, Community Services and Indigenous Affairs, *Australia's children: safe and well. A national framework for protecting Australia's children: A discussion paper for consultation*, 2008, Australian Government, p. 9.
[146] Home C, *Policy and practice paper: Effects of child abuse and neglect for adult survivors*, 2014, Child Family Community Australia, Australian Institute of Family Studies, <https://aifs.gov.au/resources/policy-and-practice-papers/effects-child-abuse-and-neglect-adult-survivors>.

undertaken by the United Kingdom's Office for National Statistics.[147] Accordingly, accurately identifying and effectively responding to childhood abuse, neglect and trauma is critical in addressing the potential later life impacts of these adversities, as noted by the National Society for the Prevention of Cruelty to Children (UK), who have stated that:

> A child's experience of abuse must never dictate their future, which is why we work directly with victims to help them recover and get their lives back on track.
>
> Although survivors may bear the scars of their experiences, this should not define who they are.
>
> Swift mental health support, resources for police to investigate child abusers, and a society that knows what abuse is and will step in if they suspect it can all help survivors go on to lead happy, fulfilled, lives.[148]

3.1.1 Families are the primary source of a child's safety

Research identifies that families 'are a child's single most important environment in terms of influence on development,' 'with family relationships and interactions being critically important:'[149]

> For most children, their family offers them love, support and a sense of belonging. While what constitutes a family can vary widely, the benefits of being part of a strong and positive family unit are more universal. A strong and positive family unit can:
>
> - help children form social networks
> - provide children with resources, care and a safe place to learn and explore [and]
> - teach children about the world and the rules that govern it.[150]

Families play a primary role in child caregiving, protection, and in the prevention of violence against children,[151] often representing 'a first layer of a child's protective environment.'[152] International human rights instruments recognise the family as 'the natural and fundamental group unit of society,'[153] with the right to family unity, protection and assistance entrenched in universal and regional human rights instruments, and international humanitarian law:[154]

> A basic assumption of the Convention on the Rights of the Child, contained in its preamble, is that the family is the natural environment for the growth and well-being of all its members – and particularly children – thereby recognizing that the family has the greatest potential to protect children and provide for their physical and emotional safety. The privacy and autonomy of the family are valued in all societies

[147] Office for National Statistics (UK), *People who were abused as children are more likely to be abused as an adult*, 27 September 2017, <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/peoplewhowereabusedaschildrenaremorelikelytobeabusedasanadult/2017-09-27>.
[148] Office for National Statistics (UK), *People who were abused as children are more likely to be abused as an adult*, 27 September 2017, <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/peoplewhowereabusedaschildrenaremorelikelytobeabusedasanadult/2017-09-27>.
[149] Australian Institute of Health and Welfare, 'Feature Article 3.1: The role of the family in child wellbeing,' Australian Government, Canberra, 2015 p.2, viewed 14 May 2020, <https://www.aihw.gov.au/getmedia/30d3e529-a599-4b39-a30b-8ac63c6617b2/AW15-3-1-role-of-family-in-child-wellbeing.pdf.aspx>.
[150] Australian Institute of Health and Welfare, *Australia's Children*, 2020, Australian Government, Canberra, p. 230.
[151] United Nations Children's Fund, *General comment no. 13: the right of the child to freedom from all forms of violence*, 2011, Committee on the Rights of the Child, Geneva, p. 2.
[152] United Nations Human Rights Council, *Report of the Special Rapporteur on the sale of children, child prostitution and child pornography, Najat Maalla M'jid*, 2013, United Nations General Assembly, New York, A/25/48, para. 32.
[153] United Nations, *United Nations Universal Declaration of Human Rights*, 1948, Article 16, New York.
[154] United Nations High Commissioner for Refugees, 'Summary Conclusions: family unity,' 2001, Geneva, p. 604, viewed 12 March 2020, <https://www.unhcr.org/419dbfaf4.pdf>.

> and the right to a private family life, a home and correspondence is guaranteed in international human rights instruments[155]

The primacy of the family is also enshrined in the Council of Australian Government's *National Framework for Protecting Australia's Children 2009-2020,* which is underpinned by the principle that 'the safety and wellbeing of children is primarily the responsibility of their families, who should be supported by their communities and governments.'[156]

In Western Australia, the role of the family is ingrained in the principal legislation governing the care and protection of children, the *Children and Community Services Act 2004,* which identifies 'the principle that the parents, family and community of a child have the primary role in safeguarding and promoting the child's wellbeing' must be observed in the administration of the Act.[157]

3.1.2 Families with multiple, chronic and inter-related problems can have difficulties in meeting children's needs and keeping children safe from harm

Not all children reside in a home 'where some or all aspects of their family are positively functioning' and, 'for some children, families may not be able to provide a safe and supportive environment.'[158]

In fact, family and domestic violence, parental drug and/or alcohol misuse and parental mental health problems frequently co-occur and are associated with child abuse and neglect within the home:

> Families with multiple and complex problems are no longer a marginal group in service delivery … they have become the primary client group of modern child protection services.[159]

However, it is important to understand that these complex problems occur within a wider context of social exclusion, poverty and trauma and do not arise as a result of individual failings, but rather as part of a complex reaction to structural, relational and distributional disadvantage:

> One might look at these data and assume that, as they are based on the characteristics of parents referred to child protection services, the statistics represent "the worst of the worst" and that most parents who experience either mental health problems, substance misuse or domestic violence will not experience multiple problems. But research into domestic violence, substance misuse and mental health as problems in their own right and separate from child protection or parenting issues shows that individuals who experience any one of these problems are likely to also experience other complex problems. …
>
> Practitioners need to be aware that parents involved with child protection services are likely to be experiencing multiple complex problems and that these problems do not just coincidently co-occur; they co-occur because they are inter-related. …

[155] Paulo Sergio Pinheiro, *Report of the independent expert for the United Nations study on violence against children*, 2006, United Nations, New York, p. 12.
[156] Council of Australian Governments, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020*, 2009, Commonwealth of Australia, Canberra, p. 12.
[157] *Children and Community Services Act 2004* (WA), s. 9(a).
[158] Australian Institute of Health and Welfare, *Australia's Children*, 2020, Australian Government, Canberra, p. 231.
[159] Bromfield L et al, *Issues for the safety and wellbeing of children in families with multiple and complex problems: the co-occurrence of domestic violence, parental substance misuse, and mental health problems: NCPC Issues 33*, 2010, National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, p. 1.

> Social exclusion manifests through multidimensional and interlinked problems - primarily poverty - but can also include unemployment, poor housing or homelessness, crime, substance addiction, teenage pregnancy, victimisation, poor education or job skills, poor health, lack of social capital and family dysfunction. … Furthermore, research has also shown that early childhood trauma contributes to social disadvantage and exclusion (Frederick & Goddard, 2007). Poverty and social exclusion are major causes of the problems that child protection services deal with in practice, yet it is unrealistic to believe that child protection and family services practitioners have the power to end poverty and social exclusion.[160]

3.2 Children and adolescents are vulnerable to violence within their families

As identified, families, including extended families, occupy a central role in child caregiving, protection, and in the prevention of violence.[161] However, children are not 'untouched' by family and domestic violence; researchers highlight 'the myriad of ways' in which children experience family and domestic violence:

> The kids growing up with domestic abuse live on your street and go to your local school. They return home each day to houses where they feel defenceless and afraid, or where it is their job to protect their mother and siblings. They know all the best places to hide, and how to make themselves disappear when the yelling starts. They hold their mother while she cries and help her wash off the blood; they comfort and hush their siblings; they call police and beg for help. They are recruited as spies. They blame themselves – and get blamed – for the violence, and they fantasise about hurting or killing their parents. They beg their mother to leave, because one day he's gonna kill her. They see their parents come home from hospital and carry on like everything is normal. They watch their father get arrested. They *know* the violence is their own fault and that if they can just find a way to be good enough, or do or say the right thing, it will stop. And deep down, many are terrified that when they grow up, they too will turn into an abuser – or end up marrying one.[162]

The research literature identifies that children living in homes characterised by family and domestic violence have previously been considered the '"silent", "forgotten", "unintended", "invisible" and/or "secondary" victims of domestic violence.'[163] Researchers also identified that child protection and family support systems, 'tended to overlook children who have been exposed to domestic violence in the mistaken belief that "children are untouched by the chaos happening around them in the family home" and a belief that the absence of physical harm meant that no real harm had occurred.'[164] Further, ANROWS has identified that 'in the majority of cases, [Child Protection] workers do not properly document the impact of violence and abuse on children … [and] minimise the impact of [family and domestic violence] on children, through the use of language that framed recorded incidents as an issue between parents only.'[165]

[160] [160] Bromfield L et al, *Issues for the safety and wellbeing of children in families with multiple and complex problems: the co-occurrence of domestic violence, parental substance misuse, and mental health problems: NCPC Issues 33*, 2010, National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, p. 13.
[161] United Nations Children's Fund, *General comment no. 13: the right of the child to freedom from all forms of violence*, 2011, Committee on the Rights of the Child, Geneva, p. 2.
[162] Hill J, *See What You Made Me Do,* 2019, Black Inc, Carlton, p. 165.
[163] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 1.
[164] Kovacs K and Tomison A, 'An analysis of current Australian program initiatives for children exposed to domestic violence', *Australian Journal of Social Issues,* 2003, 38(4), p. 514.
[165] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 3.

Increasingly, research has drawn attention 'to the myriad of ways children experience domestic violence,' with researchers identifying that 'describing this range of violent experiences as 'witnessing' fails to capture the extent to which children may become embroiled in domestic violence.'[166] Terminology used to describe children's experiences of family and domestic violence has evolved considerably in recent years, with researchers seeking to expand upon narrow and stereotypical views of a child 'witnessing' family and domestic violence:[167]

> The research literature… demonstrates that witnessing can involve a much broader range of incidents, including the child:
>
> - hearing the violence;
> - being used as a physical weapon;
> - being forced to watch or participate in assaults;
> - being forced to spy on a parent;
> - being informed that they are to blame for the violence because of their behaviour;
> - being used as a hostage;
> - defending a parent against the violence; and/or
> - intervening to stop the violence.
>
> The research literature … shows that in the aftermath of a violent incident, children's exposure to domestic violence can involve:
>
> - having to telephone for emergency assistance;
> - seeing a parent's injuries after the violence and having to assist in 'patching up' a parent;
> - having their own injuries and/or trauma to cope with;
> - dealing with a parent who alternates between violence and a caring role;
> - seeing the parents being arrested; and
> - having to leave home with a parent and/or dislocation from family, friends and school.[168]

Acknowledgement of the breadth of children's experiences in the context of family and domestic violence was also recognised by former National Children's Commissioner Megan Mitchell. In her 2015 Children's Rights Report, Commissioner Mitchell noted that stakeholders repeatedly identified that 'differentiating between witnessing violence, being exposed to violence, and/or being directly abused in the context of family and domestic violence is not helpful.'[169] The need to challenge how the system conceptualises children's experience of family and domestic violence was recently highlighted by Australian investigative journalist Jess Hill, in her award winning investigation into domestic abuse:

> These are the children we refer to as 'witnesses' who've been 'exposed' to domestic abuse. Such language does gross injustice to their experience. These children are not bystanders. They are victims in their own right, with needs, fears, and loyalties independent of their abused parent. This is a fact recognised in Australian law: exposure to domestic violence is now considered a form of child abuse.[170]

[166] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 17.
[167] Richards, K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 1.
[168] Richards, K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 1-2.
[169] National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 121-122.
[170] Hill J, *See What You Made Me Do,* 2019, Black Inc, Carlton, p. 166.

'In summary,' identifies Professor Cathy Humphreys, Co-Director of the Centre of Research Excellence to Promote Safer Families, 'the distinction between witnessing and direct abuse may be a false one and should not be the principal criterion for understanding the severity of the impact on children and their need for protection.'[171]

> There is no doubt that children who witness the homicide of their mothers will be traumatised (Hendriks et al. 1993), as will the disturbing number of children who witness the sexual assault of their mothers… However, interviews with children and young people also draw attention to how distressing it is to hear screams, the noise of the destruction of their home and seeing assault with weapons. These children often believe their mothers are on the point of being killed.172

Professor Humphreys further identifies that:

> The terminology 'children affected by domestic violence' is used to overcome the problematic divisions sometimes made between 'children witnessing domestic violence', 'children exposed to domestic violence', 'children directly abused in the context of domestic violence', 'children living with domestic violence' and 'children drawn into domestic violence'. 'Children affected by domestic violence' covers all these overlapping groups, including those where healing from trauma and disruption in the aftermath of domestic violence is an issue.[173]

'Children's involvement in domestic violence is intimate and central rather than peripheral.'[174] Accordingly, throughout this report, the Office uses the term 'children affected by domestic violence.'

3.2.1 Not all children and adolescents are equally affected by family and domestic violence; but all must be safeguarded from violence

Research regarding the impact of family and domestic violence on children 'shows widely diverging experiences,' generally highlighting 'the serious and negative impact of [family and domestic violence] on the lives of very significant numbers of children.'[175]

However, researchers also identify that, within evidence-based studies, findings highlight some children 'who are doing as well as other children, in spite of living with the serious childhood adversity created by [family and domestic violence].'[176]

> Not all children are equally affected by the violence they witness or live with, with some at serious risk of harm, even death, others are not as impacted due to specific protective factors.[177]

[171] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 18.
[172] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 17.
[173] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 3.
[174] Stanley N, *Children Experiencing Domestic Violence: A Research Review*, 2011, Darlington: Research in Practice, p. 7, cited by National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 119.
[175] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 15.
[176] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 15.
[177] Australian Psychological Society, cited by National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 127.

AIHW identifies that 'exposure to family violence alone does not mean a child will necessarily experience negative outcomes,' and that 'with the right support, children exposed to family violence may have increased resilience later in life.'[178] Harm to children is influenced by a range of social and ecological factors within the individual, family, community, and broader culture.[179] In this context, researchers highlight the need to consider more than resilience as 'an individual trait,' but rather 'that children live in different contexts of both severity and protection:'[180]

> There are considerable divergences in outcomes and impacts in different populations of children… and resilience in children is not well understood. The literature suggests that there are several factors that may mitigate children's exposure to violence, including the extent of children's peer and social support their relationship with their mother or other primary caregiver; whether the violence was ongoing or short-term; age of child when the [family and domestic violence] occurred; and whether children received an adequate response/treatment following the [family and domestic violence].[181]

Professor Cathy Humphreys challenges the 'over-pathologising of children living with domestic violence,' identifying 'there is a substantial portion of children who are managing in a situation of adversity.' However, she crucially goes on to identify 'this *must not be read* to mean that children do not have a right to live free from violence or a need to service in these circumstances.'[182]

> There can be no compromise in challenging violence against children. Children's uniqueness — their potential and vulnerability, their dependence on adults — makes it imperative that they have more, not less, protection from violence.[183]

The Australian Human Rights Commission identifies that children's 'exposure' to family and domestic violence 'has clearly been identified as a human rights issue.'[184] The international community 'has pledged to safeguard all children, everywhere and at all times' from violence.[185]

[178] Australian Institute of Health and Welfare, *Australia's children*, 2020, Australian Government, Canberra, p. 338.
[179] Humphreys C and Healey L, *PATHways and Research into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report*, 2017, Australian National Research Organisation for Women's Safety, Sydney, p. 8.
[180] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 15.
[181] Australian Institute of Family Studies and Australia's National Research Organisation for Women's Safety, cited by National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, ,p. 127.
[182] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 15.
[183] Paulo Sergio Pinheiro, *Report of the independent expert for the United Nations study on violence against children*, 2006, United Nations, New York, p. 5.
[184] Australian Psychological Society, cited by National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 105.
[185] Marta Santos Pais, 'Protecting children from violence is a Human Rights imperative,' 2011, UN Special Representative of the Secretary-General on Violence Against Children, New York, viewed 16 March 2020, <https://violenceagainstchildren.un.org/news/protecting-children-violence-human-rights-imperative>.

Further, Article 19 of the *Convention on the Rights of the Child* places obligations upon States to prevent and respond to all forms of violence against children:[186]

> Article 19
>
> 1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
>
> 2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

3.3 Family and domestic violence often co-occurs with other forms of child abuse and neglect

The research literature consistently identifies that family and domestic violence often co-occurs with other forms of child abuse and neglect:

> Distinguishing children who suffer abuse in the home from those who are 'only' exposed to domestic violence presents a considerable methodological and conceptual challenge, as these two phenomena are rarely discrete.[187]

ANROWS has identified that being in a household where there is violence 'places children at increased risk of maltreatment, including physical sexual and emotional abuse,' with 'co-occurrence of child maltreatment and neglect within families where there is [family and domestic violence] … usually estimated to occur in 30 to 50 percent of cases.'[188] One systemic review examining the intersection of child abuse and family and domestic violence identifies:

> It is known that child abuse and [family and domestic violence] often co-occur; that is, in families in which one form of violence is present, there is an increased risk for the other… Findings from Felitti et al's (1998) retrospective study of adult health maintenance organization participants showed that individuals who retrospectively reported having been exposed to one form of violence (e.g., physical abuse or [family and domestic violence]) often were exposed to multiple other adversities. Dong et al's (2004) analyses of these data found that the likelihood was significantly higher of an individual's having experienced some form of child maltreatment when there was [family and domestic violence] in the home. In that study, the prevalence of physical child abuse was 57.5% for adults who reported earlier [family and domestic violence] exposure and 21.7% for those who reported no prior exposure.[189]

[186] United Nations Children's Fund, *General comment no. 13: the right of the child to freedom from all forms of violence*, 2011, Committee on the Rights of the Child, Geneva, p. 3.
[187] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 2.
[188] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 9.
[189] Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R.C., & Moylan, C. A., 'Intersection of child abuse and children's exposure to domestic violence, *Trauma, Violence & Abuse,* 9 (2), p. 86.

Research also identifies that the co-occurrence of family and domestic violence with other forms of child maltreatment 'magnifies the detrimental effects of exposure to [family and domestic violence] on children's emotional and behavioural outcomes,' a '"double whammy" effect' that results in these children experiencing 'worse [outcomes] in later life.'[190]

These perspectives align with research about poly-victimisation (exposure to multiple types of victimisation), which identifies a relationship between the experience of childhood adversities 'and the level of adverse outcomes for children.'[191] Researchers identify that 'polyvictimi[s]ation during formative developmental periods may have detrimental and potentially lifelong biopsychosocial impacts over and above the effects of exposure to specific types of adversity.'[192] In this context, children affected by family and domestic violence 'may frequently be one feature of families in which other types of violence are also present.'[193]

3.4 Family and domestic violence incidents involving children and adolescents are often underreported

There is little reliable data on how many children are affected by family and domestic violence in Australia. One survey of 5,000 children found that 23 per cent had witnessed physical violence against their mother or stepmother.[194]

Researchers have observed limitations in the availability of data surrounding the number of children who experience family and domestic violence, and its ability to capture how children experience this violence. For example, AIHW identifies:

> Although much is known about many aspects of family, domestic and sexual violence, there are several data gaps that need to be filled to present a comprehensive picture of its extent and impact in Australia. Specifically, there is no, or limited, data on… children's experiences, including attitudes, prevalence, severity, frequency, impacts and outcomes of these forms of violence…[195]

Fundamentally, some of these limitations stem from family and domestic violence 'incidents themselves being under-reported,' resulting in a lack of data on children's involvement in these incidents.[196] Administrative data is often used to estimate the prevalence of family and domestic violence, however these:

> … data collections, such as police and hospital data, can provide some insights, these data sources are likely to underestimate the true extent of children exposed to family violence, with many children (and non-perpetrating parent/guardians) reluctant to report family violence to the police or seek necessary medical intervention.[197]

[190] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 9; and Herrenkohl TI, Sousa C, Tajima EA, Herrenkohl RC & Moylan CA, 'Intersection of child abuse and children's exposure to domestic violence, *Trauma, Violence & Abuse,* 9(2), p. 90.
[191] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, p. 9.
[192] Ford JD and Delker BC, 'Polyvictimization in childhood and its adverse impacts across the lifespan: Introduction to the special issue,' *Journal of Trauma & Dissociation*, 2018, 19(3), p. 275.
[193] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 2.
[194] Hill J, *See What You Made Me Do, 2019,* Black Inc, Carlton, p. 165.
[195] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018*, 2018, Australian Government, Canberra, p. x.
[196] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 2.
[197] Australian Institute of Health and Welfare, *Australia's Children*, 2020, Australian Government, Canberra, p. 342.

Research indicates that the presence of children can be a significant barrier to victims seeking help and reporting of family and domestic violence, particularly due to fear of family separation.[198] Child protection services are also often feared as an additional means by which family separation may occur, and are not viewed as a potential source of assistance for women experiencing family and domestic violence:

> Most women would not choose to refer their children to statutory child protection services. It is not considered a benign or voluntary system. Yet where notification/referral is mandated or expected, this step must be taken by professionals regardless of the woman's view on the subject, or the protective factors which may be in place. In effect, in many states each time a woman calls for help in a crisis she is also referring her children to statutory child protection services…
>
> Without fail, child protection research on domestic violence both in Australia and elsewhere mentions the way in which child protection workers focus on women as mothers and their 'failure to protect' their children from domestic abuse at the expense of addressing the perpetrator and his violence ...[199]

This particularly affects Aboriginal and/or Torres Strait Islander families, 'given the history of government removal of children,' and the 'current over-representation of Indigenous children in out of home care:'[200]

> While the number of children taken into out of home care remains very small relative to the number of children notified, it nevertheless remains a deeply held and constantly mentioned fear for many women experiencing domestic violence … It is, of course, compounded by the tactics of abuse by the perpetrator who may constantly instil in the woman fear that he will report her to the authorities for neglecting the children.[201]

Children are also 'especially vulnerable to being subjected to unreported violence, as perpetrators of incidents against children and young people are often their parents or a person whom they depend on for care.'[202]

3.5 Family and domestic violence can have a devastating impact upon children's lifelong physical and mental health

Researchers have found that children affected by family and domestic violence and other adverse childhood experiences, exhibit higher rates of suicidal ideation and behaviour as adults, than those who did not experience violence in the home:

> A growing body of research points to the importance of childhood factors that may contribute to suicidal ideation and behaviours. In particular, epidemiological studies have shown that the prevalence of suicidal ideation and attempts is significantly higher among adults with a history of Adverse Childhood Experiences (ACEs) including sexual abuse, physical abuse and exposure to parental domestic violence.[203]

[198] National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 123.
[199] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 9-11
[200] Richards, K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra p. 2.
[201] Humphreys C, *Issues Paper: domestic violence and child protection,* 2007, Australian Domestic and Family Violence Clearinghouse, p. 9.
[202] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, Victorian Government, Melbourne, p. 40.
[203] Fuller-Thomson E, Baird SL, Dhrodia R et al, 'The association between adverse childhood experiences (ACEs) and suicide attempts in a population based study,' *Child: care, health and development*, 2016, 42(5), p. 726.

Research examining mental health, suicide ideation and attempts establishes 'a strong association between exposure to childhood adversity and psychiatric disorders and suicidal behaviour in adulthood,' with some research also identifying 'increasing severity of childhood adversity corresponding with poorer mental health outcomes.'[204] With regard to suicide attempts and ideation specifically, the research literature identifies:

> Dube et al. used a clinic sample …found that 67% of lifetime suicide attempts, 80% of child or adolescent suicide attempts, and 64% of adult suicide attempts were attributable to having experienced 1 or more adverse childhood events…
>
> A striking finding from our study was that the highest attributable fraction corresponded with any childhood adversity and suicide attempts. More specifically, the results indicated that if childhood physical abuse, childhood sexual abuse, and having witnessed domestic violence did not occur, the prevalence of suicide attempts among women and men in the general population would have been reduced by approximately 50% and 33% respectively.[205]

From a public health perspective, this research goes on to identify that 'broad social interventions that reduce child abuse may have a beneficial impact on the reduction of psychiatric illness and suicidality in the general population.'[206]

3.5.1 Australian researchers have identified a link between family and domestic violence and self-harm and suicide by children

Family and domestic violence was the subject of significant work by former Australian Children's Commissioner Megan Mitchell, who examined the impact of family and domestic violence on Australian children:

> Family conflict and domestic violence is consistently raised as a precipitating factor for self-harm and suicide among children… adverse family experiences, including domestic violence is now seen as one of the key distal risk factors that may predispose a child or young person to suicidal behaviours.[207]

AIHW identifies that family and domestic violence 'can have a wide range of detrimental impacts on a child's development, mental and physical health, housing situation and general wellbeing' including:

- diminished educational attainment
- reduced social participation in early adulthood
- physical and psychological disorders
- suicidal ideation
- behavioural difficulties
- homelessness [and]
- future victimisation and/or violent offending[208]

[204] Afifi T, Enns M, Cox B et al, 'Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences,' *American Journal of Public Health*, 2008, 98(5), p. 946-952, viewed 4 June 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374808/>.
[205] Afifi T, Enns M, Cox B et al, 'Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences,' *American Journal of Public Health*, 2008, 98(5), p. 946-952, viewed 4 June 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374808/>.
[206] Afifi T, Enns M, Cox B et al, 'Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences,' *American Journal of Public Health*, 2008, 98(5), p. 946-952, viewed 4 June 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374808/>.
[207] Australia's Children's Commissioner Megan Mitchell, Speech at the 13th Australasian Injury Prevention Network Conference, 13 November 2017, viewed 4 June 2020, <https://humanrights.gov.au/about/news/speeches/13th-australasian-injury-prevention-network-conference>.
[208] Australian Institute of Health and Welfare, *Australia's Children*, 2020, Australian Government, Canberra, p. 338.

A significant number of studies have shown 'statistically significant effects of child exposure [to family and domestic violence] on behavioural and psychosocial/emotional problems.'[209] These impacts include:

- depression;
- anxiety;
- trauma symptoms;
- increased aggression;
- antisocial behaviour;
- lower social competence;
- temperament problems;
- low self-esteem;
- the presence of pervasive fear;
- mood problems;
- loneliness;
- school difficulties;
- peer conflict;
- impaired cognitive functioning;
- increased likelihood of substance abuse;
- eating disorders;
- suicide attempts;
- teenage pregnancy;
- delinquency; and
- violence.[210]

In 2019, the Victorian Commission for Children and Young People tabled *Lost, not forgotten,* an inquiry into children who died by suicide and were known to child protection authorities. *Lost, not forgotten* examined the lives and stories of 35 children who died by suicide between 2007 and 2019 and identified that 'the 35 children presented with multiple, often chronic, risk indicators that brought them into recurring contact with different systems.'[211]

> Factors that make children more vulnerable to suicide include exposure to adverse childhood experiences, including physical and sexual abuse, and neglect. Aboriginal children and children who have contact with the child protection system are at higher risk of dying by suicide. Children that have contact with the child protection system are at an increased risk of suicide because, as a population, they are more likely to present with risk factors associated with suicide …
>
> … Where the information was available, it revealed that children had, in most instances, experienced multiple and recurring forms of abuse. The harms these children faced were often severe.[212]

[209] Humphreys C and Healey L, *PATHways and Research into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report*, 2017, Australian National Research Organisation for Women's Safety, Sydney, p. 8-9.
[210] Richards K, *Children's exposure to domestic violence in Australia*, 2011, Australian Institute of Criminology, Canberra, p. 3.
[211] Commission for Children and Young *People (Victoria), Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 14.
[212] Commission for Children and Young *People (Victoria), Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 14.

With regard to the children's experience of family and domestic violence, *Lost, not forgotten* identified:

> Of the many risk factors present in the lives of the children reviewed the most prominent was family violence. Family violence was a feature in nearly all cases, frequently in conjunction with parental mental illness and substance abuse issues.
>
> 94 per cent of the children (n=33) were reported to have experienced family violence…
>
> … Most of the children came from families where trauma was entrenched and compounded by the 'toxic trifecta' of family violence, parental mental illness and substance abuse issues:
>
> 97 per cent (n=34) had a mother who had been the victim of family violence.[213]

In examining how systems responded to contact concerning the children, *Lost, not forgotten* further identified that:

> Most of the children in this inquiry had concurrent contact with the child protection and mental health systems. Where contact did coincide, the focus of each system was quite different. Child Protection largely assessed the circumstances of children in terms of mitigating parental risk, without addressing how exposure to these risks may have impacted the child. This was particularly the case where there was family violence. Mental health interventions, by comparison, were child-focussed – in that they focussed on addressing the mental health symptoms displayed by the child – but were not always well-informed regarding family history or the child's exposure to parental risks.[214]

3.6 The experiences of Western Australian children and adolescent victims of family and domestic violence that died by suicide

Researchers note that 'there is little to no research about understanding the impact of family violence from the young child's perspective,' and that comprehensive data collection surrounding children's experiences and perceptions of family and domestic violence is crucial in underpinning the development of services intended to assist children affected by family and domestic violence.[215]

Significant work in documenting the stories, drawings and voices of children and young people has been undertaken by the Australian Childhood Foundation in its report *Heart Felt: A collection of children's experiences and stories of abuse, recovery and hope*.[216] The Foundation notes that:

> The experience of child abuse and family violence rocks the very core of children. It changes the ways they understand their world, the people in it and where they belong. They develop distorted rules about relationships – ones that are built on mistrust, fear and betrayal. They feel out of place in their family and with their friends. They feel separate and alone. The memories of abuse are pronounced and ever present. Small reminders may cause them to relive their fear and confusion.

[213] Commission for Children and Young *People (Victoria), Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 39, 89.
[214] Commission for Children and Young *People (Victoria), Lost, not forgotten*: *Inquiry into children who died by suicide and were known to Child Protection*, 2019, Victorian Government, p. 19.
[215] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, Victorian Government, Melbourne, p. 41.
[216] Australian Childhood Foundation, *Heart Felt: A collection of children's experiences and stories of abuse, recovery and hope,* 15 December 2011, ACF, viewed 21 March 2022 <https://professionals.childhood.org.au/resources/>.

> The world itself, is experienced as dangerous for abused children – a place without haven or safety.
>
> Hope is the outcome of change for children. It is like a wave that carries them into the future with fun, enthusiasm and optimism. Hope is the first moment in time when they dare to dream. For these children, hope comes from feeling that their experiences of abuse no longer separate them from their friends and family. They know that they do not have to feel alone anymore. They start to really feel a sense of safety in themselves and in those around them.[217]

It is hoped that new insights will also be gained from the first National study of abuse and neglect in Australia, which is being conducted from 2019-2023 and will retrospectively report on childhood experiences of family violence for respondents aged 16 and over.[218]

Researchers in the United Kingdom have also conducted a few small interview-based studies with children and young people who have experienced coercive control.

In this context, the Office undertook in depth analysis of records to venture to understand the experiences of children and adolescents affected by family and domestic violence. The Office discerned a range of diverse and staggering experiences of family and domestic violence among those who went on to die by suicide as children, adolescents, and young adults.

In some instances, records surrounding a child were episodic, reflecting singular or sporadic reports of family and domestic violence, for example, an incident between caregivers and where children were sometimes present. Records for other children showed that they lived in circumstances of extreme and entrenched violence, including violence directly used against the child, reported in early childhood, and identified repeatedly throughout the course of their lives.

The Investigation has ascertained that the experiences of children and adolescents affected by family and domestic violence are confronting and devastating. They demonstrate the horror that is family and domestic violence for children and adolescents as victims and the resultant trauma. In each case below, the child or adolescent went on to die by suicide.

In order to ensure the utmost respect and dignity to victims, the following experiences have been fully deidentified.

[217] Australian Childhood Foundation, *Children's Voices*, 2020, viewed 21 March 2022 <https://www.childhood.org.au/the-impact/childrens-voices/>.
[218] QUT (Queensland University of Technology), *The first national study of child abuse and neglect in Australia: prevalence, health outcomes, and burden of disease*, 2019, Brisbane: QUT, viewed 21 March 2022, <https://research.qut.edu.au/child-adversity/projects/the-first-national-study-of-child-abuse-and-neglect-in-australia-prevalence-health-outcomes-and-burden-of-disease/>.

The experiences of family and domestic violence among children and adolescents who went on to die by suicide

- an infant boy was in his mother's arms and dropped when she was violently assaulted by members of her family.
- a toddler boy was hit across the face by his mother's partner.
- a pre-school aged child watched and cried as his father was attacked and repeatedly punched in the head by his mother.
- an adolescent boy complained of repeated physical violence from his older brother.
- an adolescent girl was assaulted by a family member and conveyed to hospital with a suspected broken bone.
- an adolescent boy called an agency from his school. Crying and distressed, he told the worker that he no longer wanted to live with his father and was scared to go home. His father told him that he would kill him if he didn't return home.
- a pre-teen girl was raped by a family member.
- an adolescent girl discovered the body of a child relative who was killed by their caregiver in an act of family and domestic violence.

The women and children in this report had suffered greatly as a result of the violence they experienced, both in an immediate and ongoing way. The details of the childhood abuse and neglect which occurred is harrowing and traumatic and is particularly difficult to read. However, it is important that we, as a State, hear the voices of these children and young adults, acknowledge the vulnerability, fear, hurt and pain they endured and recognise the need for meaningful change in the way care, support and protection is provided to them in the future. As noted by the *Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA:*

> The consistent message we have heard from children, families and carers was that they did not want other to experience the fear, anger or despair that they all too often experienced when they sought help. …
>
> We have heard children tell us they felt rejected, that their experience was one of cruelty. …
>
> The inability of services to meet the needs of children is contributing to more children seeking to hurt themselves, or worse.[219]

[219] Government of Western Australia, *Final Report: Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA*, March 2022, p. 6 and 25.

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4 Understanding the impacts of violence against Aboriginal women and children

4.1 Listening to Aboriginal voices

The Office of the Western Australian Ombudsman acknowledges the traditional owners of the land on which the office is located, the Whadjuk Noongar people. The Office pays its respects to elders past, present and emerging.

In our work, the Office aims to recognise the unique cultures, histories, knowledge, strengths and experiences of Aboriginal communities in Western Australia. The Office is guided by the truths within the *Warawarni-gu Guma (Healing Together) Statement* and recognises the significant strength and wisdom of Aboriginal women and men, drawing on their cultures, to continually resist and challenge violence in their communities.[220]

4.2 Aboriginal perspectives on family violence

4.2.1 The role of Aboriginal law and culture in promoting social and emotional and wellbeing

Aboriginal and Torres Strait Islander peoples have traditionally recognised health and wellbeing as a holistic concept, derived from their law and culture:

> [T]he Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. This holistic concept does not just refer to the 'whole body' but is in fact steeped in harmonised inter relations which constitute cultural well-being. These interrelating factors can be categorised largely into spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these inter relations is disrupted, Aboriginal ill health will persist.[221]

Prior to the arrival of European settlers, Aboriginal laws and culture (although unique to each community) shared a number of features that promoted collective safety and wellbeing through the strength of connections to culture, family and kin, country, law, and spirituality:

> Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. Their culture also provided for everyone by sharing rules and understanding relationships. Kinship was of prime importance in defining social roles. Aboriginal people were also given a sense of meaning and understanding of life experience through their connection to country and their Dreaming. Spiritual beliefs offered guidance and comfort and held a sense of connectivity and belonging despite distress, death and loss. Lore, the body of knowledge that defined the culture, was highly valued, as were the tribal Elders who contained and interpreted the Lore. Customary law defined rules and consequences. Over 200 traditional languages and other methods of communication allowed a rich expression of interaction in this social context, and formal ceremony enabled a method of dealing with life's transitions through birth, initiation and death. Men and women had defined economic and cultural roles. Children were well protected within the group with a range of aunties and older

[220] Douglas L, Wenitong M, Cox D, Muir W, Martin-Pedersen M, Masterton G, Mosby E, et al, *Warawarni-gu Guma Statement: Healing Together in Ngurin Ngarluma*, 2018, viewed 21 March 2022, <https://www.anrows.org.au/warawarni-gu-guma-statement/>.
[221] Swan P and Raphael B, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy*, 1995, p. 19.

> siblings able to take over the childcare role if the mother was fulfilling other communal responsibilities or was stressed.[222]

Accordingly, the research literature recognises 'that holistic social and emotional wellbeing approaches which nurture healthy connections to family, community, country, body, spirituality, mind, emotions, and culture, are a great source of Indigenous wellbeing and resilience.'[223] Further, building on Aboriginal and Torres Strait Islander people's holistic view of health, the 'spiritual and emotional wellbeing of families' is seen as the foundation for building and maintaining healthy communities.[224]

4.2.2 Aboriginal and Torres Strait Islander communities' perspectives on family violence

Research highlighting the voices of Aboriginal women in Western Australia indicates 'that family violence cannot be addressed as an isolated issue but needs to be understood in the whole context of all the other issues that community members are facing:'[225]

> All Aboriginal participants indicated that gender inequality was not a root cause of family violence in their community. Rather, they spoke about issues in the social context as causes of family violence, such as intergenerational trauma and its many manifestations, and alcohol use. All Aboriginal participants suggested that family violence is not part of Aboriginal culture, but that it had become normalised in some of the families and the community. … Participants' narratives indicate that the issue of family violence cannot be considered in isolation of the whole context within which people live each day. Rather, the issue of family violence must be considered in the context of family and community systems and dynamics, law and culture, the presence of alcohol and other drugs, the multiple forms of trauma present in families and communities, and the various stressors and pressures to which community members are subjected today.[226]

The research literature identifies that the scope of violence experienced in Aboriginal and Torres Strait Islander communities is broader than what is captured by non-Aboriginal definitions of domestic violence:

> Conceptualisations of domestic and family violence in Aboriginal and Torres Strait Islander families and communities are different to prevailing dominant Western theories of domestic and family violence. It has a different background, different dynamics, it looks different, it is different. It needs its own theoretical discourse and its own evaluations.[227]

[222] Parker R and Milroy H, 'Aboriginal and Torres Strait Islander Mental Health: An Overview', in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (2nd ed), 2014, 25-38, p. 26, viewed 21 March 2022 <https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/expired-projects/working-together-second-edition/>.
[223] Dudgeon P, 'Aboriginal and Torres Strait Islander women and mental health', *InPsych*, February 2017, 39(1), viewed 21 March 2022, <https://psychology.org.au/inpsych/2017/february/dudgeon>.
[224] Blagg H, Hovane V, Tulich T et al, 'Law, Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 9-10.
[225] Blagg H, Williams E, Cummings E, Hovane V, Torres M, & Woodley KN, *Innovative models in addressing violence against Indigenous women: Final report (ANROWS Horizons, 01/2018)*, 2018, ANROWS, p. 34.
[226] Blagg H, Williams E, Cummings E, Hovane V, Torres M, & Woodley KN, *Innovative models in addressing violence against Indigenous women: Final report (ANROWS Horizons, 01/2018)*, 2018, ANROWS, p. 34.
[227] Hovane V, *Our story to tell: Aboriginal perspectives on domestic and family violence (ANROWS Footprints)*, 2015, ANROWS, p. 13.

Research undertaken with Aboriginal Elders and senior community leaders, including those in Kununurra, Fitzroy Crossing and Newman, 'strongly indicates that Aboriginal peoples hold radically different understandings regarding the scope and causes of family violence, and how the issue should be tackled.'[228] Further, an Australian study on the impact of domestic violence law and policy on Aboriginal and Torres Strait Islander women identified that:

> … compared to non-Indigenous intimate partner violence, Indigenous intimate partner violence is characterised by fights, more so than coercive control. Some of these fights occur in a context of chaos in the lives of many Aboriginal and Torres Strait Islander people, particularly those living in remote Australian communities. For Indigenous people, formulaic policing of domestic violence sits within historically strained relations between them and the police, and consecutive periods of protectionism manifested as state control over their lives. Failure of Indigenous people to comply with DVOs is partly a result of chaos and perhaps resistance to state authority.[229]

The research literature also notes that:

> It is now well established that family violence experienced within Aboriginal and Torres Strait Islander communities is shaped by the specific and historical context of colonialism, systemic disadvantage, cultural dislocation, forced removal of children and the intergenerational impacts of trauma. As a result, it requires a distinct and tailored set of responses across multiple fronts led by Aboriginal communities and nested in Aboriginal and Torres Strait Islander cultural values and worldviews. [230]

Accordingly, within the research literature, the term 'family violence' is often used (rather than 'intimate partner violence' or 'domestic violence') in acknowledgment that Aboriginal and Torres Strait Islander peoples have expressed the view that this term better reflects their experiences.[231]

> Family violence involves any use of force, be it physical or non-physical, which is aimed at controlling another family or community member and which undermines that person's well-being. It can be directed towards an individual, family, community or particular group. Family violence is not limited to physical forms of abuse, and also includes cultural and spiritual abuse. There are interconnecting and trans-generational experiences of violence within Indigenous families and communities.[232]

[228] Blagg H, Hovane V, Tulich T et al, 'Law, Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 9-10.
[229] Blagg H, Williams E, Cummings E, Hovane V, Torres M, & Woodley KN, *Innovative models in addressing violence against Indigenous women: Final report (ANROWS Horizons, 01/2018)*, 2018, ANROWS p. 56.
[230] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 62-63.
[231] For example, Australian Institute of Health and Welfare, *Family violence among Aboriginal and Torres Strait Islander peoples*, Australian Institute of Health and Welfare, cat. no. IHW 17, Canberra, 2006, p. 15; Department for Child Protection and Family Support, *Family and Domestic Violence Background Paper*, Government of Western Australia, Perth, 2012, p. 2, and Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 – 2006*, Human Rights and Equal Opportunity Commission, June 2006, p. 6.
[232] Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 – 2006*, 2006, Human Rights and Equal Opportunity Commission, p. 6.

'Family violence' describes the extended family and kinship relationships 'within which a range of forms of … violence frequently occur' and an 'understanding of the inter-generational impacts of violence.'[233] The research literature identifies that:

> Aboriginal women prefer the term 'family violence' because it includes the broad range of marital and kin relationships in which violence may occur. Indigenous people may view family violence as occurring between members of their larger family network including aunts, uncles, grandparents, cousins and others in the wider community, whereas non-Indigenous people may view family violence as only that which occurs within the nuclear family.[234]

Research has also found that the term 'family violence' within Western Australia is used in at least 'fifteen different' ways, capturing:

> … everything from domestic assaults through to clan feuds, jealous fighting, sister fights, neglect of children, 'humbugging' (bullying family members for money or services), wasting money on gambling, excessive use of alcohol and/or drugs and racialized insults. All these activities impinge on the health of family life as a whole, and it is the family/clan unit, rather than the sovereign, autonomous, western individual subject, that constitutes the irreducible core of Aboriginal Law and Culture. [235]

4.2.2.1 Humbugging

'Humbugging' refers to aggressive demands for money, goods, or services, usually aimed at kin.[236] This may include behaviours such as demand sharing and asking or pressuring family members for assistance or money in an unreasonable or bothersome manner. [237]

4.2.2.2 Lateral Violence

'Lateral violence' is a term used within Aboriginal and Torres Straight Islander communities to describe 'the displacement of anger from colonial systems of control "laterally" into Indigenous families, communities, and workplaces.'[238]

This violence is the 'product of a complex mix of historical, cultural and social dynamics that results in a spectrum of behaviours'[239] such as:

- gossiping;
- jealousy;
- bullying;
- shaming;
- social exclusion;
- family feuding;
- organisational conflict; and
- physical violence.[240]

[233] Blagg H, Hovane V, Tulich T et al, 'Law, Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 3.
[234] Australian Institute of Health and Welfare, *Family violence among Aboriginal and Torres Strait Islander peoples*, 2006, cat. no. IHW 17, AIHW. Canberra, p. 15.
[235] Blagg H, Hovane V, Tulich T et al, 'Law, Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 3.
[236] Blagg et al, *Innovative models in addressing violence against Indigenous women: Key findings and future directions*, 2018, ANROWS, p. 3.
[237] Breunig R, Hasan S, and Hunter B, 'Financial Stress and Indigenous Australians', *Economic Record*, 2018. 95(308), p. 34-57, doi: 10.1111/1475-4932.12444; Weier M, Dolan K, Powell A, Muir K, and Young A., *Money stories: Financial resilience among Aboriginal and Torres Strait Islander Australians*, 2019, Centre for Social Impact - UNSW Sydney: Sydney, NSW.
[238] Blagg H et al, *Innovative models in addressing violence against Indigenous women: Key findings and future directions*, 2018, ANROWS, p. 2.
[239] Australian Human Rights Commission, *Social Justice Report 2011*, 2011, Aboriginal and Torres Strait Islander Social Justice Commissioner, p. 54.

4.2.3 Family violence is not part of Aboriginal and Torres Strait Islander cultures

Professor Michael Dodson AM, a prominent advocate on issues affecting Australian Aboriginal and Torres Strait Islander people, has stated:

> We have no cultural traditions based on humiliation, degradation and violation.
>
> Let me make this point abundantly clear.
>
> Most of the violence, if not all, that Aboriginal communities are experiencing today are not part of Aboriginal tradition or culture.[241]

Similarly, former Aboriginal and Torres Strait Islander Social Justice Commissioner Dr William Jonas AM identified that while prevalent, family violence is not 'normal' or 'culturally acceptable:'

> And it is not part of our systems of customary law. In fact, it is the reverse. It is an indication of the fragility of such customary law and a sign of the breakdown in traditional governance mechanisms in communities. It is, in short, an indication of community dysfunction ...[242]

In 'yarning' with Aboriginal Elders and senior community leaders in Northern Australia, (including those in Kununurra, Fitzroy Crossing and Newman) ANROWS researchers identified that Aboriginal and Torres Strait Islander peoples 'were united in their beliefs that family violence is one of the most significant threats to the future of communities and is tearing family life apart':

> Similarly, participants were anxious to negate the view that violence against women and children was an acceptable part of Aboriginal and Torres Strait Islander Law and Culture, which was in line with Professor Mick Dodson's assertion that "the violence occurring in Aboriginal communities today is not part of Aboriginal tradition or Culture. It is occurring principally because of the marginalisation of Aboriginal people." Similarly, the LRCWA [Law Reform Commission of Western Australia] stated that it is the destruction of Aboriginal customary law and the breakdown of traditional forms of maintaining order and control that has impacted on the extent of violence and sexual abuse in Aboriginal communities. This was a consistent thread in discussions with communities.[243]

Aboriginal women speaking to researchers highlighted their view that 'they have always had gender equality, evidenced by the fact that they have possessed their own laws and dreaming, patterns of governance, and roles in relationships to the Earth and to the community.'[244]

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[240] Blagg H, Bluett-Boyd N and Williams E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, 2015, ANROWS, p. 6, <https://www.anrows.org.au/publication/innovative-models-in-addressing-violence-against-indigenous-women-final-report/>.
[241] Dodson M, 'Violence Dysfunction Aboriginality,' 11 June 2003, National Press Club, Canberra, p. 2.
[242] Jonas W, 'Family violence in Indigenous communities: Breaking the silence?', *Australian Human Rights Commission*, 25 July 2002, viewed 12 December 2021, <https://humanrights.gov.au/about/news/speeches/family-violence-indigenous-communities-breaking-silence>.
[243] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 62.
[244] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 36.

Further, Aboriginal women also:

> … consistently maintained that how Women's Law works and how Men's Law works is very different to the assumptions being expressed or portrayed in the mainstream (that is, that Aboriginal Culture and Law are primitive or violent and discriminate against women, and that there is no gender balance or equality): "Both men and women must work together … 'this is the proper way'." …
>
> Women Elders do not believe they are subordinate to men or that they don't have a say within the community—they believe that their place and Culture are being misrepresented and downplayed by white people who either do not understand Culture or have their own political agenda. There was a widespread belief that current family violence policies are too focused on gender inequality, mirroring concerns raised in the literature. There was also a widespread belief that current family violence policies downplay the significance of inherited traumas, jealousy, alcohol and other addictions on people's behaviour (both men and women). …
>
> The participants from the Kimberley, Northern Territory and Pilbara said during the yarning groups that conflicts between partners or individual family members should be dealt with together. They also support the idea of "truthtelling"—that the guilty party needs to own up to their own wrongful behaviour/s. [245]

4.2.4 Aboriginal and Torres Strait Islander responses to family violence

4.2.4.1 The role of law and culture

The voices of Aboriginal and Torres Strait peoples mirror 'views in the literature that Law and Culture were vital forces in their lives.' [246] As noted by ANROWS, Aboriginal and Torres Strait Islander peoples have long called for cultural responses to family violence to be funded in order to address the ongoing unmet need for healing and prevention 'that covers the whole spectrum of violence on communities':

> Women's Law was viewed as essential for preventing and resolving family violence. Women Elders from Kununurra said Law—especially Women's Law—and Culture bring strength and unity to the community. …
>
> For Aboriginal people, Aboriginal law sets out the norms, beliefs, expectations and rules for everyday living. Aboriginal law is stable and enduring and embedded within it is dignity, wellbeing and equality between men and women. The day to day living and expression of Aboriginal law is "culture". Family violence has no basis in either Aboriginal law or culture.
>
> … Aboriginal Law and Culture, and in particular Women's Law, was viewed as essential to preventing and resolving family violence and healing and empowering individuals and communities. As Martu Elders told us: Getting men and women and families living together, being together, working together, on-country is the solution for much family violence … People get well on-country, particularly without alcohol.[247]

[245] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 46-52.
[246] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 10.
[247] Blagg H, Tulich T, Hovane V et al, *Understanding the role of Law and Culture in Aboriginal and/or Torres Strait Islander communities in responding to and preventing family violence (Research report, 19/2020),* 2020, Sydney: ANROWS, p. 10-13.

Recent research undertaken in Queensland has found evidence that cultural connection, engagement and reduced levels of discrimination are associated with lower suicide rates among Aboriginal and Torres Strait Islander young people:

> Although cultural devastation is widely acknowledged to be a factor in the high suicide rates for Aboriginal and Torres Strait Islander people, investigation of the protective effects of community empowerment and cultural connectedness has been limited. … Both researchers and Elders have promoted community strengths and community level protective factors to foster the wellbeing of children and adolescents, and consequently to prevent suicide. Specifically, it has been suggested that community cultural connectedness protects against the unique challenges that First Peoples face as the result of the systemic legacies of colonisation.
>
> The "cultural continuity" model proposes that community level cultural factors protect against youth suicide among First Nations peoples by facilitating perceptions by young people of their connectedness with a past and future cultural lineage. Its proponents posit that identifying with a culture with bonds stretching into the past and positive projections into the future can reinforce a young person's connection with and commitment to their personal futures during periods of change or disruption of self-identity, reducing their suicide risk. …
>
> We identified associations between suicide mortality rates for young Aboriginal and Torres Strait Islander people and culturally specific risk and protective factors at the community level. Specifically, the age-adjusted suicide rate was 80% higher in areas classified as having lower levels of cultural social capital; that is, it was 44% lower in communities with high cultural social capital, where larger proportions of First Nations people participate in cultural events, ceremonies, organisations, and community activities, and were more involved with their community. The rate was higher in communities with higher levels of reported discrimination. Our findings suggest, as others have also proposed, that suicide by young Aboriginal and Torres Strait Islander people is influenced by factors often not included in traditional models of suicide causation.[248]

4.2.4.2 Innovations and promising practices

It is important to acknowledge that 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 such as night patrols.

[248] Gibson M, Stuart J, Leske S, Ward R and Tanton R, 'Suicide rates for young Aboriginal and Torres Strait Islander people: the influence of community level cultural connectedness', *Med J Aust*, 2021; 214(11): 514-518, doi: 10.5694/mja2.51084.

4.3 Aboriginal family violence in context

4.3.1 Historical context

While most Aboriginal and Torres Strait Islander people 'do not experience physical or threatened harm', numerous reports, inquiries, journal articles and published statistics have established that Aboriginal women and children are vulnerable to experiencing violence at vastly disproportionate rates.[249]

As noted in the Australian Human Rights Commission Report *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future*, the overrepresentation of Aboriginal and Torres Strait Islander peoples in official statistics is 'indicative of the entrenched social, economic and cultural disadvantage that we face':[250]

> In 2014–15, approximately one in eight (13%) Aboriginal and Torres Strait Islander people aged 15 years and over, experienced physical violence in the last 12 months, 8% had experienced physical violence on more than one occasion.
>
> Aboriginal and Torres Strait Islander women make up 16% of all female murder victims in Australia and also make up 10% of unsolved missing persons cases.[251]

More particularly, as stated by Australia's National Research Organisation for Women's Safety (ANROWS), 'high rates of family violence cannot be uncoupled from the history of colonial settlement and the multiple traumas resulting from dispossession.'[252]

Identifying and understanding the impact of violence against Aboriginal women and children in Western Australia requires recognition of the historical, cultural, spiritual, social and environmental issues against which this violence has developed:[253]

> It is not possible to know Aboriginal and Torres Strait Islander people's, or women's full experience of violence without also knowing non-Aboriginal and Torres Strait Islander people's, or men's, full experience of violence and how these separate experiences inform and shape human behaviours in the whole.[254]

[249] Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework - Measures: 2.10 Community Safety*, 2020, viewed 21 March 2022, <https://www.indigenoushpf.gov.au/measures/2-10-community-safety>; Australian Department of Social Services, *Fourth Action Plan – National Plan to Reduce Violence against Women and their Children 2010-2022*, 2019; Bartels L, *Emerging issues in domestic/family violence research*, 2010, Australian Institute of Criminology, viewed 21 March 2022 <https://www.aic.gov.au/publications/rip/rip10>; Closing the Gap Clearinghouse, *The role of community patrols in improving safety in Indigenous communities*, 2013; Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities*, 2006; 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*, 2002, Department of Premier and Cabinet, Western Australia.

[250] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, p. 42.

[251] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report,* 2020, p. 42; Cussen T and Bryant W, 'Indigenous and non-Indigenous homicide in Australia', Australian Institute of Criminology, 5 May 2015, <https://www.aic.gov.au/publications/rip/rip37>; and Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia, 2018*, <https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary>.

[252] Blagg H, Williams E, Cummings E et al, *Innovative models in addressing violence against Indigenous women: Final report (ANROWS Horizons, 01/2018)*, 2018, ANROWS, p. 64.

[253] Blagg H, Hovane V, Tulich T et al, 'Law Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 5-6.

[254] Atkinson J, *Trauma trails, recreating song lines: The transgenerational effects of trauma in Indigenous Australia*, 2002, Spinifex Press, p. 17.

The history of Aboriginal peoples in Western Australia prior to colonisation was summarised by the Royal Commission into Aboriginal Deaths in custody as follows:

> It is well documented that Aboriginal people occupied and traversed what is now known as Western Australia many thousands of years prior to colonisation. The level of resource management was considerable, with a viable hunting, gathering and fishing subsistence pattern. There is also evidence of husbandry and farming which were to successfully provide countless generations with a productive and spiritually rich existence. Seasonal exploitation of regional resources, and the maintenance of socio-cultural ties and religious practices ensured the continuation of Aboriginal people and their cultural integrity.
>
> Aboriginal Law regulated relationships between individuals and groups. The demarcation of a group's land or 'country' was clear and respected. Everything that existed, whether living or inert, had meaning and integration to a world that not only constituted the here and now, but also that which continued from before. The land gave and sustained, not only life, but also the basis for meaning and intelligence to questions of order, responsibility and obligations for Aboriginal people. There was nothing to conquer in the land because the people belonged to the land. Their power and sense of being came from it. Pride and esteem emanated from celebrating the land which included the cosmos and the intricate interaction of spiritual beings, whose continuing action gave meaning, purpose and strength to all living and non-living things. Indeed, to life itself. Knowledge and practice of these mysteries is what gave pride and wisdom, not material possessions. Into this intelligently balanced material and spiritual world of early 19th century Aboriginal Australia, came the British colonisers, with their perceived superiority and arrogance which informed their denial of the rights of indigenous peoples.[255]

Western Australia has a violent colonial history, preserved in the records of documentary evidence and the oral histories of our Aboriginal communities. Unlike the 'national legacy of unutterable shame' arising from widespread childhood removals and practices of removing Aboriginal and Torres Strait Islander peoples from their land, the details of Western Australia's colonial history remain 'largely unknown and acknowledged'[256] by the public at large, despite documented incidents of shocking cruelty noted in the Regional Report for Western Australia prepared for the Royal Commission into Aboriginal Deaths in Custody, including:

- the 1833 shooting death of Yagan, whose 'smoked head [was] removed and placed on public exhibition in Britain';
- the 1834 Pinjarra massacre;
- the 1926 killing and burning of Aboriginal people in the Forrest River District in the East Kimberley;
- the practice of neck and body 'chaining' Aboriginal prisoners in Yirramagardu/ Leramugado (Roebourne), Wadjemup (Rottnest Island) and other locations;
- the enslavement of Aboriginal men and women as 'agricultural and pastoral workers and domestics' on stations, particularly in the Kimberley;
- bans on Aboriginal people from entering towns, including Perth, not lifted until 1954;
- the sexual exploitation of Aboriginal women by non-Aboriginal men;

[255] Australian Royal Commission into Aboriginal Deaths in Custody, *Royal Commission into Aboriginal Deaths in Custody: National reports [Vol. 1-5], and regional reports*, 1991, Australian Government Publishing Service, viewed 21 March 2022, <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/wa_underlying/17.html>.
[256] Carmody S, 'The ghosts are not silent', *ABC News Background Briefing*, 17 September 2021, viewed 15 March 2022 <https://www.abc.net.au/news/2021-09-17/wonnerup-minninup-massacre-the-ghosts-are-not-silent/100458938>.

- reports of Police 'carrying out unmitigated killings on Aboriginal people throughout the [Kimberley] region' in the late 19th century and early 1900s; and
- the 'design and implementation of Government policies and legislation … to create institutional control over Aboriginal peoples lives without too much emphasis being placed upon Aboriginal legal, social and cultural requirements.'[257]

Researchers note that 'controls over Aboriginal women's bodies was critical to the settler project … Aboriginal women were particularly affected by policies designed to destroy Indigenous family life.'[258] In summary, as noted in the Telethon Kids Institute report *Aboriginal and Torres Strait Islander children and child sexual abuse in institutional contexts*:

> Aboriginal and Torres Strait Islander people were dehumanised and women and children sexualised. Allegations of abuse against them were denied even in the face of overwhelming evidence. While colonisation broke up diverse and sophisticated systems of governance and lore in traditional Aboriginal and Torres Strait Islander communities, this was replaced with a western legal system that discriminated against Aboriginal and Torres Strait Islander peoples, provided little protection and actively prevented parents from caring for their children.[259]

4.3.2 Contemporary context

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.[260]

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 multiple government inquiries and reports.[261]

[257] Dodson P, *Royal Commission into Aboriginal Deaths in Custody: Regional report of inquiry into underlying issues in Western Australia*, 1991, Australian Government Publishing Service, viewed 21 March 2022, <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/wa_underlying/17.html>.
[258] Blagg H, Hovane V, Tulich T et al, 'Law, Culture and Decolonisation: The perspectives of Aboriginal Elders on Family Violence in Australia', *Social & Legal Studies*, 2021, 1-24, p. 5-6.
[259] Anderson P, Bamblett M, Bromfield L et al, *Aboriginal and Torres Strait Islander children and child sexual abuse in institutional contexts: Report for the Royal Commission into Institutional Responses to Child Sexual Abuse*, 2017, Sydney, p. 18.
[260] Healing Foundation, *Our Healing Our Way: Leading and shaping our future – National Youth Healing Forum Report*, 2017, p. 4.
[261] AIHW, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015,* 2015,; AIHW, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018, in brief*, 2018; 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*, 2012; Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, 2016; 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*, 2016, Legislative Assembly, Parliament of Western Australia; 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*, 2017, Australian Government; Holland C, *Close the Gap 2018: A ten-year review: the Closing the Gap Strategy and Recommendations for Reset*, 2018.

Colonisation is widely regarded as an ongoing process that continues to impact the social and emotional wellbeing of Aboriginal and Torres Strait Islander people today, as highlighted by suicide researchers Ernest Hunter and Helen Milroy:

> For many, to survive in the face of trauma across generations, including the forcible removal of children and repeated violations of self and family, demanded that feelings be repressed or dissociated, that the realities of exclusion be denied or distorted (living "as if" one was accepted as part of the wider Australian society), or simply finding the strength to endure with the hope that future generations would be spared the pain of those in the past and present. …
>
> With the rapid social changes from the 1970s the numbing that previously supported survival lifted and long stifled emotions emerged, at times unregulated and overwhelming … fuelled by unrestricted access to alcohol (and later other substances) the behavioural consequences included risk-taking, violence, and the undermining of capacity to address the responsibilities of family and community life. Increasingly, children's experience of families included the depression, fear and rage of parents and others. In this time of turmoil one might wonder how children could make sense of their world while their parents were struggling to come to terms with their own experiences. While now able to contemplate a future that was inconceivable for earlier generations, these parents were increasingly aware of the tragic legacies of the past, levels of loss and trauma that were profound and ongoing. The deliberate damage to Indigenous family and kinship structures created confusion, frustration and resentment compounded by deception and discrimination that persists. The harm to culture and the sanctity of life has devastated the purpose, volition and agency, critical to cultural continuity and integrity, resulting in a state of discontinuity and incoherence within a dominant society which remains invested in denial, rationalization and trivialization of past policies and practices and which still defines the values by which such injustices are considered and recompense in the present contemplated. While Indigenous children of earlier generations were often raised in situations where parents' rights were systematically violated, contemporary children confront a generation of parents amongst whom many have ''gone missing'' as new ''freedoms'' transformed into poverty, fragmented existence and cultural exclusion. Blame is conveniently apportioned (to the victims, Indigenous parents) and, ironically, rationalizes past racist legislation and practice.[262]

Aboriginal communities interviewed as part of the Australian National University's Family and Community Safety for Aboriginal and Torres Strait Islander Peoples Study (FaCtS) identified intergenerational trauma and structural disadvantage as stressors leading to family violence:

> Community members overwhelmingly described family and community violence in relation to its historical context. They viewed contemporary violence as stemming from colonisation and the related violence enacted on Aboriginal and Torres Strait Islander peoples and communities, perpetuated by intergenerational trauma and the undermining of traditional gender structures. Individuals and communities have experienced severe and widespread trauma across generations, with limited capacity to address it. Key forms of trauma include forced removal from Country, disconnection from culture, separation of families (including through the Stolen Generations, incarceration and child removals), exposure to racism, and witnessing and experiencing violence. In some instances, unresolved trauma results in damaged family structures, making it difficult to establish and maintain healthy relationships; this, in turn, continues the perpetration and experience of violence.

[262] Hunter E and Milroy H, 'Aboriginal and Torres Strait Islander Suicide in Context', *Archives of Suicide Research,* 2006, 10(2), 141-157, p. 147-148.

> Participants described a set of interrelated factors as the catalysts of violence – housing problems, racism, financial stress, alcohol and other drug use, poor physical health and loss of social and emotional wellbeing (SEWB) – including mental health difficulties, unemployment, contact with the justice system and incarceration. Trauma and the negative impacts of ongoing colonisation were identified as the common underlying causes of these catalysts.
>
> Analysis of quantitative data from the Community Member Survey supports these qualitative findings. The prevalence of experiencing and using violence was significantly lower among those who had less exposure to trauma, discrimination, and violence; stable income, employment, and housing; no exposure to the justice system or incarceration; no problems with alcohol and other drug use at the individual, family or community level; and better individual, family and community health and wellbeing.[263]

4.3.2.1 Experiences of inequity

While noting that the real extent of family violence 'and the impact of family violence on women and child victims is unknown because there are many barriers to reporting family violence,'[264] population survey data indicates that family violence occurs at higher rates for Aboriginal and/or Torres Strait Islander Australians than for non-Indigenous Australians.'[265] In particular, AIHW identifies that:

- In 2014–15, 1 in 7 (14%) Indigenous women experienced physical violence in the previous year. Of these, about 1 in 4 (28%) reported that their most recent incident was perpetrated by a cohabiting partner (ABS 2016).
- From 2012–13 to 2013–14, 2 in 5 Indigenous homicide victims (41%) were killed by a current or previous partner, twice the rate of non-Indigenous victims (22%) (Bryant & Bricknell 2017).
- In 2014–15, Indigenous women were 32 times as likely to be hospitalised due to family violence as non-Indigenous women, while Indigenous men were 23 times as likely to be hospitalised as non-Indigenous men (SCRGSP 2016).
- In 2015–16, Indigenous children were 7 times as likely to be the subject of substantiated child abuse or neglect as non-Indigenous children (AIHW 2017a).[266]

The research literature highlights that Aboriginal and/or Torres Strait Islander women, particularly younger women, are more vulnerable to family violence, with women aged 25-34 years and 34-44 years 'most likely to have experienced family and domestic violence:'[267]

> Violence is a significant cause of morbidity and mortality in Australia's Indigenous population, with women predominantly being the victims. According to Oberin (2001:25), 'domestic and family violence has an even more major impact on Aboriginal and Torres Strait Islander women than it does on other groups of Australian women'. In addition, Bagshaw et al. (2000:123; cited in Women's Services Network 2000:8) state that 'considerable evidence exists which suggests

[263] Guthrie J, Thurber K, Lovett R et al, *The answers were there before white man come in': stories of strength and resilience for responding to violence in Aboriginal and Torres Strait Islander communities - Family Community Safety for Aboriginal and Torres Strait Islander Peoples Study Report*, 2020, Australian National University, p. 15.
[264] Dudgeon P, Blustein S, Bray A, et al, *Connection between family, kinship and social and emotional wellbeing*, 2021, Indigenous Mental Health and Suicide Prevention Clearinghouse, Australian Institute of Health and Welfare, Canberra, p. vi.
[265] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia*, 2018, AIHW, Canberra, p. xi.
[266] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia*, 2018, AIHW, Canberra, p. xi – x.
[267] Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander Women's Experiences of Family and Domestic Violence, 2019, viewed 12 December 2021, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20women's%20experiences%20of%20family%20and%20domestic%20violence%20(Feature%20Article)~10100>.

> that Indigenous women are far more likely to be victims of domestic violence than non-Indigenous women and they sustain more injuries'.[268]

In acknowledging the 'high levels and severity of family violence in Aboriginal and/or Torres Strait Islander communities,'[269] and that Aboriginal and/or Torres Strait Islander women 'are targeted more than any other group in Australia,'[270] Aboriginal and/or Torres Strait Islander researchers importantly identify:

> This does not however, mean that family violence affecting Aboriginal victims/survivors, predominantly women and children, is exclusively the domain of Aboriginal communities – or that all perpetrators of violence against Aboriginal women are Aboriginal men. There is insufficient data on the Aboriginality of perpetrators and FVPLS Victoria routinely sees Aboriginal clients, mostly women, who experience family violence at the hands of men from a range of different backgrounds and cultures, Aboriginal and non-Aboriginal. The only certainty in the existing data is that Aboriginal women are at disproportionately higher risk of family violence.[271]

4.3.2.2 Mental health impacts and suicidality

The research literature has also highlighted ongoing effects on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples arising from intergenerational trauma:

> There is strong empirical evidence documenting the extent and intergenerational effects of Australia's past policies of forced removal of WA Aboriginal children from their natural families on rates of family breakdown, mental health problems and suicidal behaviour among families impacted by these policies. Similar increased rates of social and mental health problems have been documented among Canadian Indigenous families affected by abuse and historical trauma which occurred within that country's residential school system.[272]

It is thought that social exclusion and disconnection from protective cultural factors including 'social contact/community support', 'family and friends', 'removal from family' and the 'influence of Elders' disrupt cultural continuity and young people's ability to 'have a sense of their past and their cultures … [and] conceive of themselves as having a future (as bearers of that culture).'[273]

[268] Al-Yaman F, Van Doeland M and Wallis M, *Family Violence among Aboriginal and Torres Strait Islander peoples*, 2006, Australian Institute of Health and Welfare, Canberra, p. 2-3.
[269] Aboriginal Family Violence Prevention & Legal Service Victoria, 'Submission to the Victorian Royal Commission into Family Violence,' 2015, FVPLS Victoria, Melbourne, p. 22.
[270] Hill J, *See What You Made Me Do,* 2019, Black Inc, Carlton, p. 300.
[271] Aboriginal Family Violence Prevention & Legal Service Victoria, 'Submission to the Victorian Royal Commission into Family Violence,' 2015, FVPLS Victoria, Melbourne, p. 22.
[272] Silburn S, Zubrick SR, Lawrence DM et al, 'The Intergenerational Effects of Forced Separation on the Social and Emotional Wellbeing of Aboriginal Children and Young People', *Family matters,* 2006, *75*, p. 10-17.
[273] Dudgeon P, Calma T and Holland C, 'The context and causes of the suicide of Indigenous people in Australia', *The Journal of Indigenous Wellbeing: Te Mauri*, 2017, 2(2), p. 5-15.

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Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	October 2022
A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee	September 2022
A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020	September 2021
An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	July 2021
Preventing suicide by children and young people 2020	September 2020
A report on giving effect to the recommendations arising from 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

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Investigation into family and domestic violence and suicide

Volume 3: Contact between victims of family and domestic violence who died by suicide and State government departments and authorities

Ombudsman Western Australia

About this Report

This report is available in print and electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with disability. Requests should be directed to the Publications Manager.

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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 emerging.

CONTENT WARNING

This report contains information about suicide, family and domestic violence 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 women and children who died by suicide.

The Institution of the Ombudsman

The institution of the Ombudsman is more than 200 years old. The institution of the Ombudsman promotes and protects human rights, good governance and the rule of law as recognised through the adoption in December 2020 by the United Nations General Assembly of Resolution 75/186, *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*.

The International Ombudsman Institute, established in 1978, is the global organisation for the cooperation of 205 independent Ombudsman institutions from more than 100 countries worldwide. The International Ombudsman Institute is organised in six regional chapters - Africa, Asia, Australasian and Pacific, Europe, the Caribbean and Latin America and North America.

Ombudsman Western Australia

Ombudsman Western Australia is one of the oldest Ombudsman institutions in the world. The Ombudsman is an independent and impartial officer who reports directly to Parliament. The Ombudsman receives, investigates and resolves complaints about State Government agencies, local governments and universities, undertakes own motion investigations, reviews child deaths, reviews family and domestic violence fatalities and undertakes inspection, monitoring and other functions.

The Ombudsman concurrently holds the roles of Energy and Water Ombudsman and Chair, State Records Commission.

Ombudsman Western Australia: Proud of Diversity

The office of the Western Australian Ombudsman takes pride in diversity and equal opportunity. The office stands with the LGBQTIA+ community. The Ombudsman's pronouns are he/him/his.

The Ombudsman Western Australia and Aboriginal Western Australians

Ombudsman Western Australia acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of this land. We recognise and respect the 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 emerging.

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Getting help and finding support

If a life is in danger, or someone you know is at immediate risk of harm, call 000.

If you, or someone you are with is highly distressed, feeling unsafe and thinks they are a risk to themselves, go to your nearest emergency department.

If you are worried about a person who refuses to go to an emergency department, and need urgent mental health assistance, please contact:

Mental Health Emergency Response Line: 1300 55 788 (Perth) or 1800 676 822 (Peel)

rapid response for after-hours mental health emergencies in the Perth and Peel metro areas, or connection to your local mental health service during business hours

Rurallink: 1800 552 003 (regional Western Australia, free call)

specialist after hours mental health telephone service for people in rural communities, 4.30 pm to 8.30 am, Monday to Friday and 24 hours Saturday, Sunday and public holidays, and for connection to your local mental health service during business hours

Suicide Call Back Service: 1300 659 467 or suicidecallbackservice.org.au

free phone, video and online counselling for people at risk of suicide, concerned about someone at risk, bereaved by suicide and people experiencing emotional or mental health issues

Child and Adolescent Mental Health Service Crisis Connect: 1800 048 636

phone and online videocall support for children and young people experiencing a mental health crisis as well as support and advice to families and cares, available seven days a week from 8.30 am to 2.30 pm across the Perth metro area

Australia-wide 24 hour mental health support lines

Lifeline: 13 11 14 or lifeline.org.au

24 hour telephone crisis support and suicide prevention online crisis support chat available from 7 pm to midnight AEST

13 YARN 13 92 76

the first national crisis support line for mob who are feeling overwhelmed or having difficulty coping, they offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal & Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week

Beyond Blue: 1300 22 4636 or beyondblue.org.au

immediate support available 7 days a week, through phone (24 hours), online chat (3 pm to 12 am) or email (response within 24 hours)

1800RESPECT: 1800 737 732 or 1800respect.org.au

24 hour phone and web chat counselling for people impacted by sexual assault, domestic or family violence and abuse

MensLine Australia: 1300 78 99 78 or mensline.org.au

phone, video and web counselling for men who want to take responsibility for their violence and have healthy and respectful relationships.

StandBy Support After Suicide: 1300 72 77 47

a program focused on supporting anyone who has been bereaved or impacted by suicide at any stage in their life

Additional support services

Women's Domestic Violence Helpline: 1800 007 339

provides support for women, with or without children, who are experiencing family and domestic violence in Western Australia (including referrals to women's refuges)

Men's Domestic Violence Helpline: 1800 000 599

provides telephone information and referrals for men in Western Australia who are concerned about their violent and abusive behaviours

Crisis Care: 9223 1111 or 1800 199 008

provides Western Australia's after-hours response to reported concerns for a child's safety and wellbeing and information and referrals for people experiencing crisis

Sexual Assault Resource Centre: (08) 6458 1828 or freecall 1800 199 888

provides a range of free services to people affected by sexual violence

Derbarl Yerrigan Health Service: 9241 3888 or dhys.org.au

health and medical support for Aboriginal people, including counselling, Mon-Fri 9am to 5pm

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

phone, web chat or email counselling support for people affected by complex mental health issues, available from 10 am to 10 pm AEST

GriefLine: 1300 845 745 (landlines) or (03) 9935 7400 (mobiles) or griefline.org.au

free phone counselling and support for people experiencing grief, loss and trauma, 6 am to midnight AEST, seven days a week

Active Response Bereavement Outreach (ARBOR): 1300 11 44 46 or arbor.bereavement@anglicarewa.org.au

a free service offering short-medium term grief counselling, practical & emotional support, appropriate referral support, volunteer lived-experience peer support, and support groups to people recently impacted by losing loved ones to suicide

QLife: 1800 184 527 or qlife.org.au

3 pm to midnight, 7 days per week, telephone and webchat counselling for LGBTI people

Support services for children and young people

Kids Helpline: 1800 55 1800 or kidshelpline.com.au

24 hour telephone and web chat support for kids, teens and young adults from 5 to 25 years and their parents, carers, teachers, and schools

headspace: headspace.org.au/eheadspace

free telephone and online support and counselling for children and young people 12 to 25 years, their families and friends

Children and Young People Responsive Suicide Support (CYPRESS): 1300 11 44 46 or info@anglicarewa.org.au support service for children and young people between the ages of 6 and 18 who have been bereaved by suicide

Translating and interpreting

If you are assisting someone who does not speak English, first call the Translating and Interpreting Service (**TIS**) on 13 14 50 and they can connect you with the service of your choice and interpret for you.

If you, or the person you are assisting, has a hearing or speech impairment, contact the National Relay Service online or via their Helpdesk on 1800 555 660 and quote 08 9220 7555 to be connected with the Ombudsman's office.

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1 Background

1.1 The Ombudsman's role in reviewing family and domestic violence fatalities

On 21 September 2011 the (then) Premier, the Honourable Colin Barnett MLA wrote to the Ombudsman regarding the establishment of a family and domestic violence fatality review process and the decision of the family and domestic violence fatality working group that it would be most appropriate for this fatality review function to be conducted by the Office of the Ombudsman.

Subsequently, on 1 July 2012, the Office commenced an important new function to review family and domestic violence fatalities in Western Australia.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the person who died; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

1.2 State-wide prevalence of family and domestic violence in Western Australia during the investigation period

The Office obtained data from WA Police concerning family and domestic violence incidents reported and responded to in the investigation period (between 1 January 2017 and 31 December 2017).

1.2.1 WA Police recording systems and requirements

WA Police uses two systems for recording the work of police officers; Computer Aided Dispatch (**CAD**), and Incident Management System (**IMS**).

WA Police's CAD system generates 'CAD incidents' for the attention and response of frontline police officers and allows District Officers to monitor and manage the deployment of staff. CAD Dispatch Priorities are used to indicate the urgency of a CAD incident, and identify whether urgent, immediate, or routine attendance is required, or whether management of an incident will be undertaken by a police District or Sub-District. CAD can also be also used by frontline officers to record the circumstances of an incident.

WA Police also use IMS to generate incident reports to record information about alleged criminal incidents and offences. IMS also 'remains the WA Police's primary recording method for [family and domestic violence].'[1]

On 1 July 2017, amendments to the *Restraining Orders Act 1997* came into force. These legislative changes were also the catalyst for changes to WA Police policy and recording of family and domestic violence.

[1] Western Australia Police Force, 'WA Police – Family Violence Procedural Guidelines,' Western Australian Government, Perth, 1 July 2017, p. 11.

As of 1 July 2017, the manner in which WA Police record family and domestic violence is determined by *WA Police Family Violence Procedural Guidelines*, which identify that both IMS (in the form of Family Violence Incident Reports (**FVIR**) or Incident Reports (**IR**)) and CAD 'are the approved systems for the recording of family violence incidents.'[2] WA Police recording requirements for family violence are 'dependent upon the circumstances of the incident,'[3] and the relationship between its parties, as shown in Table 1 and Table 2:

Table 1: Terminology used to describe relationships in WA Police Family Violence Incident Reports

Immediate Family	Extended Family
Partner / ex-partner	Every other family or personal relationship which is not listed as immediate family
Parents	
Guardians of children	
Children who reside or regularly stay with involved parties	

Source: WA Police

Table 2: Terminology used to describe family violence incidents, offences, relationships and reporting requirements across the WA Police family violence incident reports and computer aided dispatch systems

		Immediate	Extended
	FV offence (with / without Police Order made)	FVIR	IR
or	No FV offence – Police Order made	FVIR	CAD
or	FV Red File / FV Alerts for FVIR submission	FVIR	CAD
or	No FV Offence – No Police Order made	CAD	CAD
An officer has discretion to submit an FVIR when considered appropriate outside of these recording requirements.			

Source: WA Police

WA Police's *Family Violence Procedural Guidelines* identify reporting requirements for family violence incidents between individuals who share an 'immediate family' relationship. When WA Police detect a family violence offence, where a Police Order is made, or where parties to an incident are the subject of a family violence alert, WA Police are required to complete a FVIR in IMS.

WA Police reporting requirements for family violence are less stringent where parties to an incident are not classified as immediate family and where no offence has been detected. However, 'WA Police must still be able to recall full incident details for inclusion in matters such as death reviews which may occur years after the incident. To meet this obligation a full account of the incident in CAD must be maintained in the absence of a FVIR/IR.'[4]

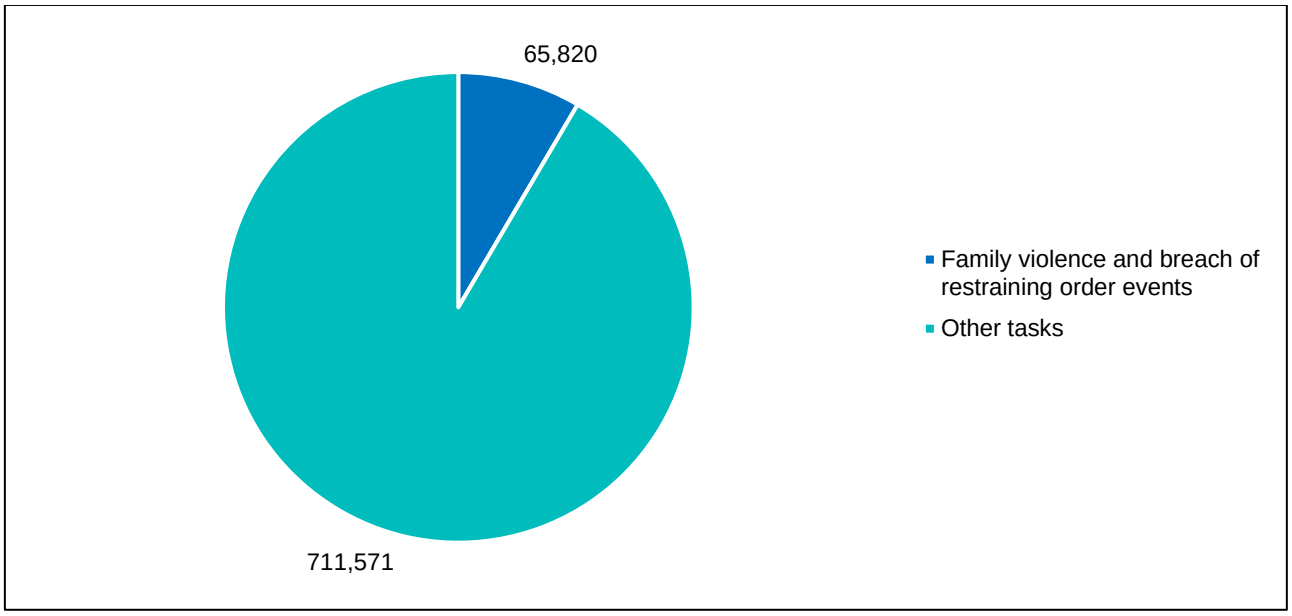
[2] Western Australia Police Force, *WA Police – Family Violence Procedural Guidelines*, 1 July 2017, p. 8.
[3] Western Australia Police Force, *WA Police – Family Violence Procedural Guidelines*, 1 July 2017, p. 8.
[4] Western Australia Police Force, *WA Police – Family Violence Procedural Guidelines*, 1 July 2017, p. 10.

1.2.2 In the investigation period, nearly one in 10 tasks allocated by WA Police were family and domestic violence related

In the investigation period, WA Police reported that it responded to 757,736 tasks where WA Police were required to attend to provide assistance to the Western Australian public. Additionally, WA Police reported a further 19,655 tasks that were managed at the district level, with WA Police follow up and tasks scheduled locally. Combined, there were 777,391 tasks requiring attendance or follow up action by WA Police between 1 January 2017 to 31 December 2017.

Of these tasks, 60,919 (8 per cent) were recorded by WA Police as 'family violence events,' and a further 4,901 (1 per cent) were recorded as a breach of a violence restraining order (Figure 1). These figures were obtained through WA Police's CAD system and show that family violence events and breaches of a restraining order constituted 9 per cent of tasks attended by frontline police officers and actioned at a local level by WA Police in 2017.

Figure 1: Family and domestic violence and breach of restraining order events, Western Australia, 2017



Source: WA Police and Ombudsman Western Australia

1.2.3 Almost one in five incidents attended by WA Police were related to family and domestic violence, some 48,836 incidents

During the investigation period, WA Police generated 276,240 incident reports on IMS. Of these incident reports, 222,682 (80 per cent) related to an incident where WA Police detected that an offence had been committed.

As identified, WA Police's primary recording method for family and domestic violence is IMS. Of the 276,240 incident reports generated by IMS during the investigation period, 48,836 (18 per cent) related to family and domestic violence. This translates to an average of 133 family and domestic violence incidents attended each day by WA Police.

WA Police's records in IMS distinguish between 'family violence incidents (general)' where there is an act of family and domestic violence between the parties involved in the incident, and 'family violence incidents (crime)' where there is an act of family and domestic violence and police officers detect that an offence has been committed.

Of the 48,836 family violence incidents attended by WA Police in the investigation period, WA Police detected an offence in 28,744 incidents (59 per cent).

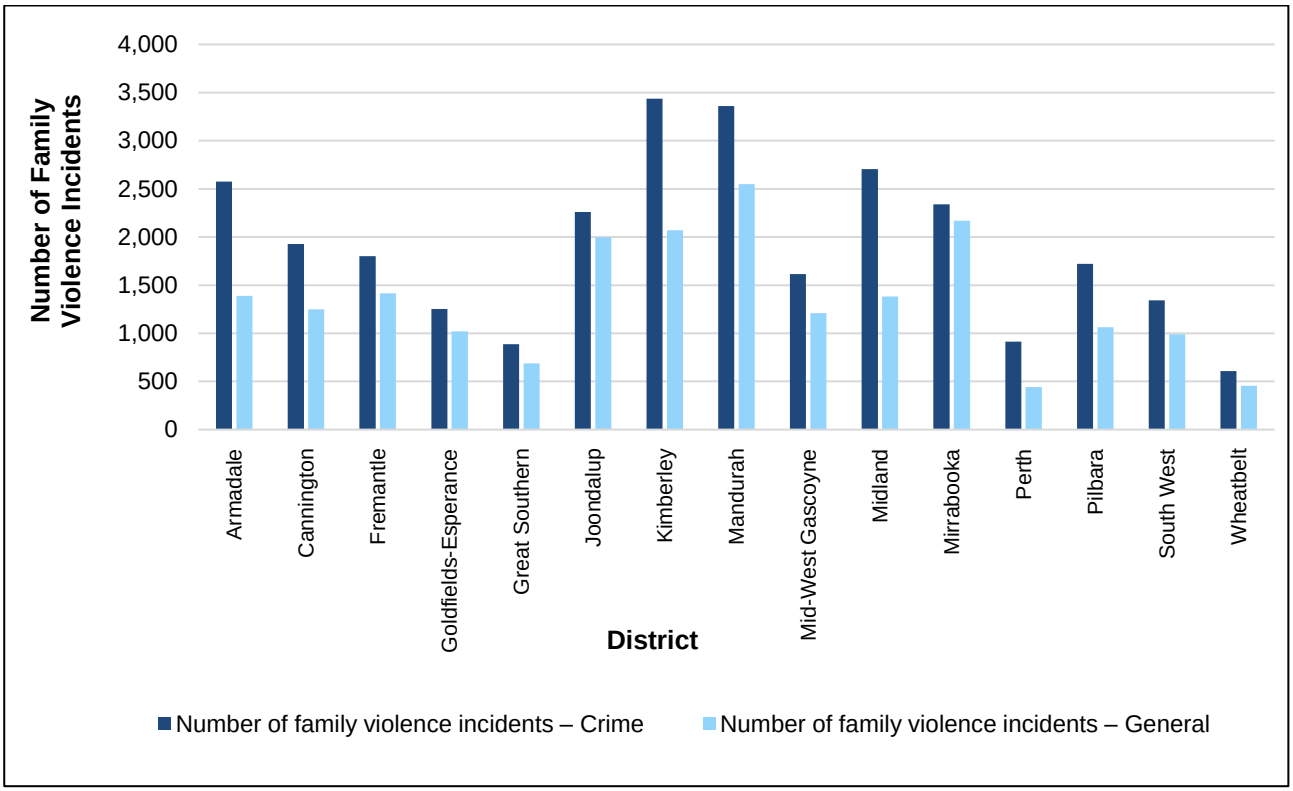
1.2.4 Despite having the lowest population of all regions in Western Australia, the Kimberley recorded the second highest number of incidents among WA Police districts

The 48,836 family violence incidents recorded by WA Police occurred throughout Western Australia. The Office found that:

- sixty two per cent (30,474) of family violence incidents occurred in metropolitan Police Districts and 38 per cent (18,362) in regional Police Districts (for comparison, the Australian Bureau of Statistics identifies that 80 per cent of Western Australia's population resides in the metropolitan area);[5] and
- despite having the lowest population of all regions in Western Australia,[6] the Kimberley Police District had the:
    - second highest number of family violence incidents; and
    - highest number of family violence incidents where an offence was detected (Figure 2).

[5] The Australian Bureau of Statistics refers to 'Greater Perth', an area the ABS notes contain not only the urban area of the capital city, but also surrounding and non-urban areas where much of the population has strong links to the capital city, through for example, commuting to work. The Office identified the 'Greater Perth' area as the closest equivalent ABS region to the metropolitan Police Districts. Australian Bureau of Statistics, *Population by Age and Sex, Regions of Australia, 2019,* cat. No. 3235.0, ABS, Canberra, August 2020.
[6] The Office identified 'Western Australia – Outback North' area as the closest equivalent ABS region to the Kimberley Police District. Australian Bureau of Statistics, *Population by Age and Sex, Regions of Australia, 2019,* cat. No. 3235.0, ABS, Canberra, August 2020.

Figure 2: Family violence incidents reported to WA Police by district, 2017



Source: WA Police and Ombudsman Western Australia

As noted, the research literature identifies difficulties with ascertaining accurate rates of family and domestic violence in any context, as it is not always reported. Researchers also identify that 'family violence is even less likely to be disclosed to formal services in rural and remote areas than in urban contexts [with victims facing] social and geographical issues that are specific to the experience of domestic and family violence living in non-urban communities.'[7] Despite these barriers to reporting, a number of Australian studies suggest that those living in regional, rural and remote areas are more likely to have experienced family and domestic violence:

- The ABS [Australian Bureau of Statistics] Personal Safety Survey (2013) showed that 21% of women living outside of capital cities had experienced violence from an intimate partner since the age of 15 (compared to 15% of women living in a capital city).
- The Australian Longitudinal Study on Women's Health (Mishra et al., 2014) found that women in rural, regional and remote areas were more likely to have experienced partner violence than women living in capital cities.
- An analysis of domestic violence cases reported to the New South Wales police in 2010 found that more incidents of domestic and family violence were reported in regional, rural and remote areas (Grech & Burgess, 2011).[8]

[7] Campo M and Tayton, S, *Domestic and family violence in regional, rural and remote communities: An overview of key issues*, 2015, Australian Institute of Family Studies, Melbourne, viewed 11 September 2020, p. 2-3, <https://aifs.gov.au/cfca/publications/domestic-and-family-violence-regional-rural-and-remote-communities>.
[8] Campo M and Tayton, S, *Domestic and family violence in regional, rural and remote communities: An overview of key issues*, 2015, Australian Institute of Family Studies, Melbourne, viewed 11 September 2020, p. 2-3, <https://aifs.gov.au/cfca/publications/domestic-and-family-violence-regional-rural-and-remote-communities>.

Family and domestic violence researchers, Australia's National Research Organisation for Women's Safety, have identified that 'there is limited research on the coping and help-seeking activities for regional, rural, and remote Australian women when they are surviving domestic violence,' further identifying 'the experiences of women living in social and geographical isolation as a priority topic for research.'[9]

1.2.5 Women were 72 per cent of the victims of family and domestic violence recorded by WA Police in the investigation period

As identified, WA Police recorded 48,836 family violence incidents on IMS in the investigation period and detected an offence in 28,744 of these incidents (59 per cent).

From these incidents, WA Police identified 20,800 unique victims of family violence. WA Police provided further information regarding these victims, including their 'gender' and 'ethnic appearance.'[10] WA Police data relating to 'ethnic appearance' refers to a variable determined and recorded by police officers when completing an incident report.

Of the 20,800 unique victims of family violence offences identified by WA Police:

- 14,886 (72 per cent) were recorded as female;
- 6,227 (30 per cent) were Aboriginal and/or Torres Strait Islander; and
- 2,035 (10 per cent) were children (recorded as being under 18 years of age at the time of their family and domestic violence experience).

As identified, WA Police data shows that 72 per cent of all victims of family and domestic violence in the investigation period were female, and ten per cent were children (under the age of 18).

WA Police data also shows that over 70 per cent of the 19,897 unique suspects in family and domestic violence incident reports were male.

This finding aligns with the research literature, which identifies that 'the overwhelming majority of victims of family and domestic violence are women and children'[11] and 'the overwhelming majority of perpetrators are men.'[12]

[9] Wendt S, Chung D, Elder A, Hendrick A and Hartwig A, *Seeking help for domestic and family violence: Exploring regional, rural, and remote women's coping experiences: Key findings and future directions*, 2017, Australia's National Research Organisation for Women's Safety, Sydney, p. 1.
[10] Both 'gender' and 'ethnic appearance' are terms referring to variables as recorded in WA Police systems and in WA Police data provided to the Office.
[11] Community Development and Justice Standing Committee, *Opening Doors to Justice: Supporting victims by improving the management of family and domestic violence matters in the Magistrates Court of Western Australia*, 2020, Legislative Assembly, Parliament of Western Australia, Perth, p. 14.
[12] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030*, 2020, Department of Communities, Perth, p. 18.

In resisting and responding to violence with the use of force, or in demonstrating behaviour that is likely to 'challenge our culture's dominant 'real' victim stereotype,'[13] the actions of some victims are not seen in the context of broader violence:

> Significantly … victims of family violence might engage in defensive or retaliatory behaviours as a response to violence. Where police use an incident-specific lens and do not see the context of the violence, this may erode the legitimacy of a woman's [or victim's] 'victimhood'.[14]

Researchers identify that these factors influence police decision making.[15] In 2010, the Australian Law Reform Commission observed that, if police 'fail to identify the "primary aggressor" and the "primary victim" when attending a scene of family violence … [this] may mean that victims are wrongly charged with family-violence related offences and inappropriately having protection orders taken out against them.'[16] A Western Australian stakeholder also observed that:

> The view put forward by the Western Australia Police is that, although understanding the nature of domestic violence is crucial to ensuring an effective response, ultimately members are only able to respond to the circumstances before them. In ambiguous circumstances, an understanding of who is likely to be the primary aggressor will be a useful guide. However, if the female is the one who clearly appears to be threatening to commit an act of family and domestic violence, the police are obliged to respond to the circumstance before them. According to police, this means that, just as it is not the role of police to take into consideration circumstances that may amount to a defence when considering whether to arrest for the commission of an offence, police are obliged to issue an order against the woman notwithstanding that she may have been subjected to acts of domestic violence many times in the past.[17]

1.2.6 Aboriginal and/or Torres Strait Islander women are overrepresented as victims of family and domestic violence

As identified, 30 per cent of those who were recorded as a victim of family violence offences during the investigation period were identified by WA Police as Aboriginal and/or Torres Strait Islander.

[13] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[14] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 4.
[15] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[16] Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, Australian Government, Canberra, section 9.158, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[17] Centacare Safer Families Support Service, quoted by Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, Australian Government, Canberra, section 9.163, viewed 21 June 2021, <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.

Making up 3.8 per cent of Western Australia's population,[18] Aboriginal and/or Torres Strait Islander people are overrepresented as victims of family and domestic violence offences in the investigation period. This was also identified in the Office's 2015 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* which stated that:

> While Aboriginal and Torres Strait Islander people make up 3.1 per cent of Western Australia's population, Aboriginal people comprised 33 per cent of victims of family and domestic violence offences committed against the person detected by [WA Police].[19]

These findings are consistent with the research literature which identifies that Aboriginal people are 'more likely to be victims of violence than any other section of Australian society', and that Aboriginal people experience family and domestic violence at 'significantly higher rates than other Australians.'[20]

1.2.7 Most family and domestic violence is not reported to police

As identified in Volume 2 and the Ombudsman's 2015 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* victims of family and domestic violence may disclose the violence to others for the purpose of obtaining support, advice, or assistance.[21] The research literature refers to these strategies as 'help seeking behaviour' and identifies that help seeking behaviour falls into two broad categories, informal and formal.[22]

Victims of family and domestic violence may seek help informally from people within their 'social network including family, friends, neighbours or colleagues,' or from formal sources including institutions such as police and 'professional services such as counsellors or crisis accommodation.'[23]

[18] Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians June 2016*, 2018, cat. no. 3238.0.55.001, ABS, Canberra and Australian Bureau of Statistics, *Regional Population by Age and Sex, Australia*, 2020, cat. no. 3235.0,ABS, Canberra.
[19] Ombudsman Western Australia *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, 2015, Ombudsman Western Australia, Perth, p. 107.
[20] Cripps K and Davis M, *Communities working to reduce Indigenous family violence*, June 2012, Indigenous Justice Clearinghouse, New South Wales; Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 – 2006*, June 2006, Human Rights and Equal Opportunity Commission, p. 6.
[21] Gourash, 1978, quoted by Lumby, B and Farrelly T*, Family Violence, Help-Seeking and the Close-Knit Aboriginal Community: Lessons from Mainstream Service Provision*, 2009, Australian Family and Domestic Violence Clearinghouse, Sydney, p. 1.
[22] In using the term help-seeking behaviour, research literature supports the view that victims engage in self-help by resisting violence and seeking safety and dignity prior to disclosing violence, and recognises that help-seeking does not necessarily first occur when a victim contacts authorities. See Richards K and Lyneham S, *Help-seeking strategies of victim/survivors of human trafficking involving partner migration*, 2014, Australian Institute of Criminology, Canberra, viewed 20 September 2021, <https://www.aic.gov.au/publications/tandi/tandi468>.
[23] Meyer S, *Responding to intimate partner violence victimisation: Effective options for help-seeking (Trends and Issues: No. 389)*, 2010, Australian Institute of Criminology, Canberra, p. 1; Richards K and Lyneham S, *Help-seeking strategies of victim/survivors of human trafficking involving partner migration*, 2014, Australian Institute of Criminology, Canberra, viewed 20 September 2021, <https://www.aic.gov.au/publications/tandi/tandi468>.

Researchers identify that victims of family and domestic violence seek help informally from family and friends prior to seeking help formally. On this point, the research literature identifies that:

> Studies show that abused women turn first to those closest to them—extended family, friends, and neighbors—before they reach out to an organization or professional service provider. Relatively few access shelter services. And they seek out government institutions—police, courts, and child protection agencies—last.[24]

The research literature consistently identifies that family and domestic violence goes largely unreported to police and other formal services. The Australian Institute of Health and Welfare's (**AIHW**) 2016 Personal Safety Survey, found that people 'who experienced violence from a current partner … were unlikely to contact the police after physical and/or sexual violence from a partner,' with 82 per cent of women and 97 per cent of men never contacting the police.[25]

The Australian Medical Association also notes that, for women found to have experienced violence at the hands of their partners, 'more than 25 per cent of women who experienced this violence never told anyone; 39 per cent sought advice or support; and 80 per cent never contacted police.'[26]

Notably, Western Australia's Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities reported that:

> [O]f those women who experienced violence from their partner in the last 20 years, 80 per cent had not sought help from services at all. Only five per cent experiencing violence from a current partner reported the last incident to police.[27]

Further, in Western Australia, the Department of Communities reports that 'fewer than 25 per cent of women experiencing family and domestic violence contacted police or a specialist service.'[28]

Research undertaken in New South Wales with victims of family and domestic violence who had already sought help from domestic violence services examined the reporting of violence to police. This research identified that, of the 300 victims interviewed, approximately half reported the most recent incident to police.[29] Of those victims who did not report the most recent incident of violence:

> [T]he most commonly cited reasons were fear of revenge or further violence from the offender (13.9%), feelings of shame or embarrassment (11.8%), and a belief that the incident was too trivial or unimportant (11.8%). One in 10 (10.4%) respondents, however, stated that they had not reported the incident because they had previously had a bad or disappointing experience with the police. A

[24] Family Violence Prevention Fund, *Family Violence: Community Engagement Makes the Difference*, 2002, p. 2.
[25] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: Continuing the national story*, 2019, Australian Government, Canberra, p. 19.
[26] Australian Medical Association, *Family and Domestic Violence AMA Position Statement*, 2016, viewed 24 June 2021, <https://www.ama.com.au/position-statement/family-and-domestic-violence-2016>.
[27] 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*, 2002, Department of Premier and Cabinet, Western Australia, p. 46.
[28] Department for Child Protection and Family Support, *Family and Domestic Violence Response Team Evaluation Report: July – December 2013*, 2014, Government of Western Australia, Perth.
[29] Birdsey E and Snowball L, *Reporting violence to police: a survey of victims attending domestic violence services: Issue Paper No. 91*, October 2013, New South Wales Bureau of Crime Statistics and Research, p. 1.

further 7.6 per cent had not reported the matter because they thought the police would be unwilling to do anything about the violence.[30]

1.2.8 Data about victims' contact with State government departments and authorities for reasons related to family and domestic violence, and for other reasons, is limited

Both general population survey data and WA Police data measure the prevalence of family and domestic violence. However, general population survey data 'does not specifically target people who have experienced these forms of violence,'[31] and WA Police data is limited to reported incidents and recording of particular sociodemographic characteristics.

Path to Safety identifies that 'some groups are at greater risk of family and domestic violence and/or face barriers to supports.'[32] Researchers have identified that these data limitations also apply to particular at risk groups including:

- Aboriginal and Torres Strait Islander people
- young people
- children, both as witnesses and victims
- pregnant women
- sexually and gender diverse people
- people on student and partner visas
- newly settled migrants
- people living in rural and remote areas
- people from culturally and linguistically different backgrounds
- children and adults living with disability
- the elderly[33]

Comprehensive data for at risk groups of family and domestic violence is therefore 'less reliable, limited or missing.'[34]

[30] Birdsey E and Snowball L, *Reporting violence to police: a survey of victims attending domestic violence services: Issue Paper No. 91*, October 2013, New South Wales Bureau of Crime Statistics and Research, p. 5-6.
[31] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018*, 2018, Australian Government, Canberra, p. 41.
[32] Department of Communities, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030*, 2020, Government of Western Australia, Perth, p. 19.
[33] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018*, 2018, Australian Government, Canberra, p. 42.
[34] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018*, 2018, Australian Government, Canberra, p. 42.

2 Suicide of family and domestic violence victims in Western Australia

2.1 Introduction

Coronial inquests and other forms of death reviews, including the Office's own child death reviews and family and domestic violence fatality (homicide) reviews, have frequently identified that women and children experiencing family and domestic violence prior to their death have often had repeated contact with State government departments and authorities.[35]

Australia has a number of obligations relevant to family and domestic violence under three international human rights treaties, namely:

- the *International Covenant on Civil and Political Rights*;
- the *Convention on the Elimination of All Forms of Discrimination Against Women*; and
- the *Convention on the Rights of Persons with Disabilities*.

As noted by the Australian Human Rights Commission (**AHRC**):

> These cascading obligations include the obligation to protect and promote; the right to life and the right to be free from gender-based violence. Both of these rights are underpinned by obligations to prevent death and prevent violence against women and children. This in turn imposes an obligation to act with due diligence to prevent, investigate, punish and provide remedies for acts of violence regardless of whether these are committed by private or State actors. The obligation to act with due diligence includes various elements, such as the duty to; investigate incidents of violence against women, collect data and to provide appropriate training to relevant personnel.[36]

Accordingly, as recommended by the AHRC, this report seeks to '[examine] the ways in which our systems and services performed when they were most challenged … [and investigate] the history of service engagement by the deceased.'[37]

Improving our understanding of contact between State government departments and authorities and the women and children with experiences of family and domestic violence prior to their death by suicide is vitally important to preventing similar deaths occurring in the future, as each contact 'provides an opportunity to recognise and respond.'[38]

In other Australian jurisdictions, family and domestic violence related suicides account for the greatest number of family and domestic violence fatalities and have been shown to have 'higher levels of service contact.'[39]

[35] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017* (**NSW 2015-2017 Report**), 2017, New South Wales Government, Sydney; *Child RM* [2020] WACOR 14; Domestic and Family Violence Death Review and Advisory Board, *Domestic and Family Violence Death Review and Advisory Board 2019-2020 Annual Report* (**Qld FVDR Report**), 2021, Queensland Government, Brisbane.
[36] Australian Human Rights Commission, *A National System for Domestic and Family Violence Death Review*, December 2016, p. 15.
[37] AHRC, *A National System for Domestic and Family Violence Death Review,* December 2016, p. 7.
[38] Qld FVDR Report 2020-21, p. 12.
[39] Qld FVDR Report 2020-21, p. 55; NSW 2015-2017 Report.

In Western Australia there is currently no ongoing review or public reporting of family and domestic violence related suicides outside of the child death reviews and own motion investigations conducted by the Office. Statistics developed and captured by the State Coroner are collected on a regular basis for uploading into the National Coronial Information System (**NCIS**), however data is only accessible to 'coroners, court staff, forensic pathologists, other medical, scientific or legal professionals tasked with assisting a coroner, and … police whose role involves the investigation of death … subject to approval by the State or Chief Coroner of the requesting jurisdiction.'[40]

2.2 The 68 women and children who were identified victims of family and domestic violence in WA Police, courts and tribunals, WA Health, child protection and corrective services records and died by suicide

The Office reviewed all of the records, data and information obtained from State government departments and authorities during the course of this investigation relating to the 410 people who died by suicide in Western Australia from 1 January 2017 to 31 December 2017.

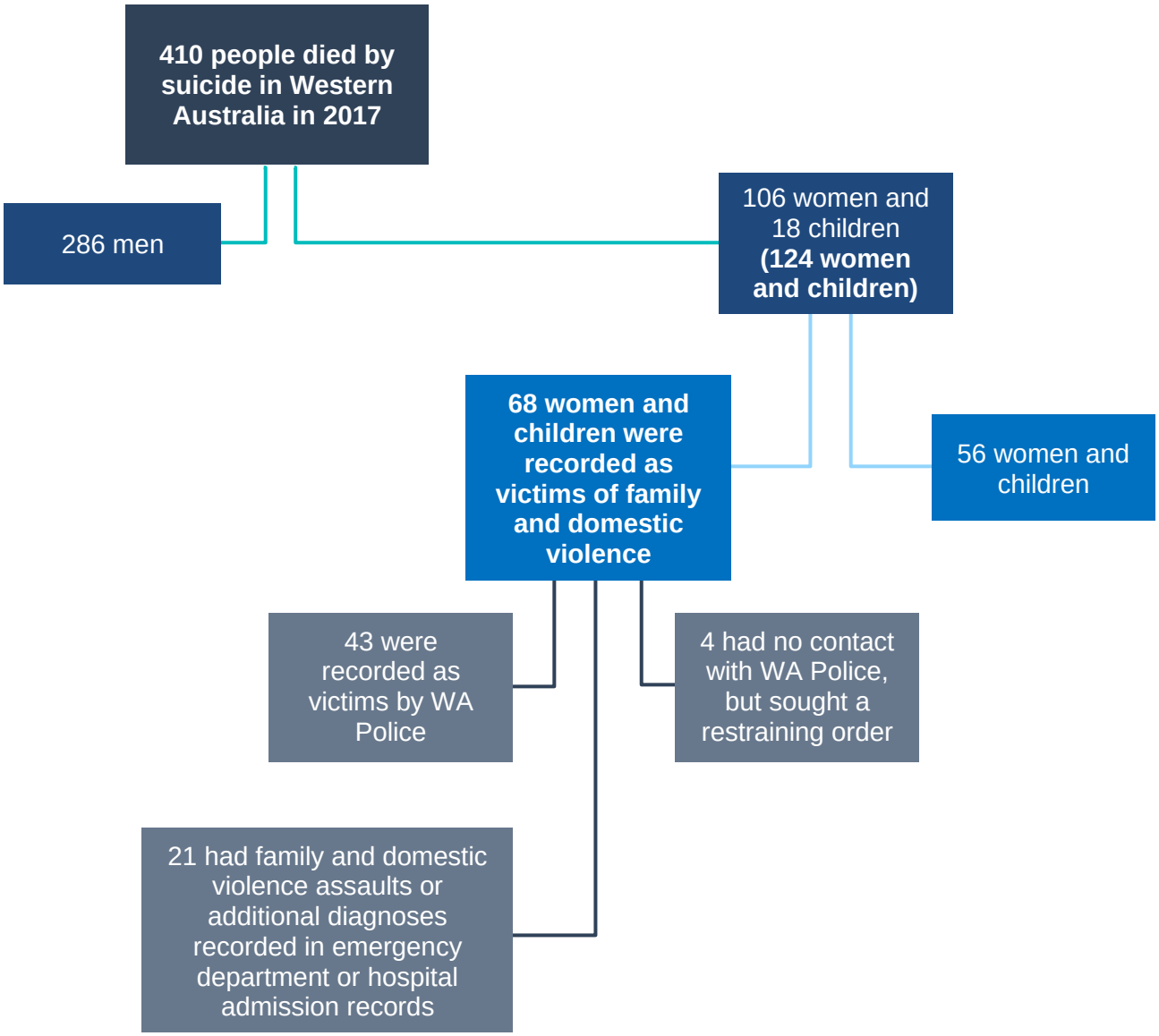
The Office provisionally coded information about each person's circumstances of death and contact with State government departments and authorities, including whether family and domestic violence occurred prior to death.

The Office then cross-checked the information from each agency and, where relevant, this review also included information obtained by the Office during child death reviews and family and domestic violence fatality reviews. Finally, for each of the 124 people identifying as women and children that died by suicide, the Office settled its provisional coding on whether they were victims of family and domestic violence known to State government department and authorities based on the totality of the information received, as shown in Figure 3.

The Office's review of these records identified that 68 women and children who died by suicide had been identified as a victim of family and domestic violence by State government departments and authorities prior to their death. Throughout this report, we refer to these victims of family and domestic violence who died by suicide as **the 68 women and children.**

[40] National Coronial Information System, 'Data access', viewed 21 April 2022 <https://www.ncis.org.au/data-access/request-for-death-investigator-access/>.

Figure 3: 68 of the 124 women and children who died by suicide were identified by State government departments and authorities as victims of family and domestic violence



Source: Ombudsman Western Australia

Among the 68 women and children (Figure 3) assessed by the Office as being victims of family and domestic violence prior to their suicide, there were:

- nine children aged under 18 at the time of their death, three of whom were Aboriginal and/or Torres Strait Islander;
- eleven women between the ages of 18 and 25, two of whom were Aboriginal and/or Torres Strait Islander; and
- forty-eight women aged 26 or older at the time of their death, seven of whom were Aboriginal and/or Torres Strait Islander.

A summary of the demographic characteristics of the 68 women and children is provided in Table 3.

Table 3: Demographic characteristics of the 68 women and children

Age	
10 to 14 years	2
15 to 19 years	8
20 to 24 years	5
25 to 29 years	7
30 to 34 years	7
35 to 39 years	5
40 to 44 years	11
45 to 49 years	8
50 to 54 years	5
55 to 59 years	3
60 to 64 years	3
65 to 69 years	2
70 to 74 years	1
85 plus years	1
Gender	
Female	62
Male	6
Aboriginality	
Aboriginal and/or Torres Strait Islander	12
Non-ATSI	56
Remoteness of Residence	
Inner Regional	5
Major Cities	52
Outer Regional	4
Remote	3
Very Remote	4
SEIFA-IRSD decile rank (within WA)	
1	15
2	4
3	4
4	10
5	2
6	7
7	2
8	6
9	10
10	6
No Fixed Permanent Address	2

Source: Ombudsman WA

2.3 Overview of contact between the 68 women and children and State government departments and authorities

This volume (Volume 3), *Contact between victims of family and domestic violence who died by suicide and State government departments and authorities*, contains data about each of the 68 women and children and their contacts with:

- the WA Police;
- courts, in the context of criminal matters, court counselling and support services for victims of crime, and restraining orders made under the *Restraining Orders Act 1999*;
- corrective services;
- hospital emergency departments and inpatient wards; and
- child protection services.

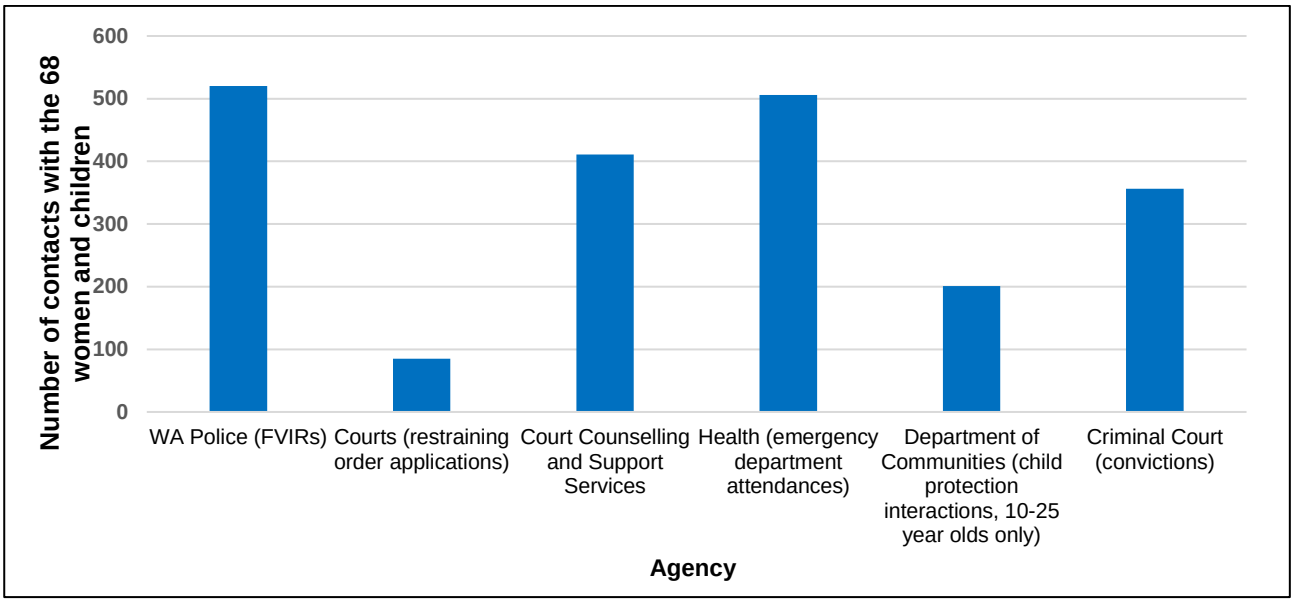
Accordingly, the data in this volume relating to the contact between State government departments and authorities is limited to data provided by the WA Police, the Department of Justice, the Department of Health and Health Service Providers and the Department of Communities.

Although this data captures many experiences of the women and children who were victims of family and domestic violence in dealing with the service system in Western Australia prior to their death by suicide, it is acknowledged that:

- further analysis is required to get a complete picture of longer-term trends and experiences with government funded services and contact where family and domestic violence was not a presenting issue;
- this data does not capture the interaction between services and the women and children who experienced family and domestic violence that was unreported prior to their suicide, including those who may have spoken about their experiences with others such as family and friends;
- contact between the women and children who died by suicide and other agencies and non-government organisations is not captured; and
- the data does not always clearly distinguish between contact where family and domestic violence is the presenting issue or an underlying issue, and where another issue is the primary reason for contact.

The contact between State government departments and authorities documented in this Volume ranges from one-off contact with a single agency to a high number of repeated contacts across multiple agencies, as shown in Figure 4:

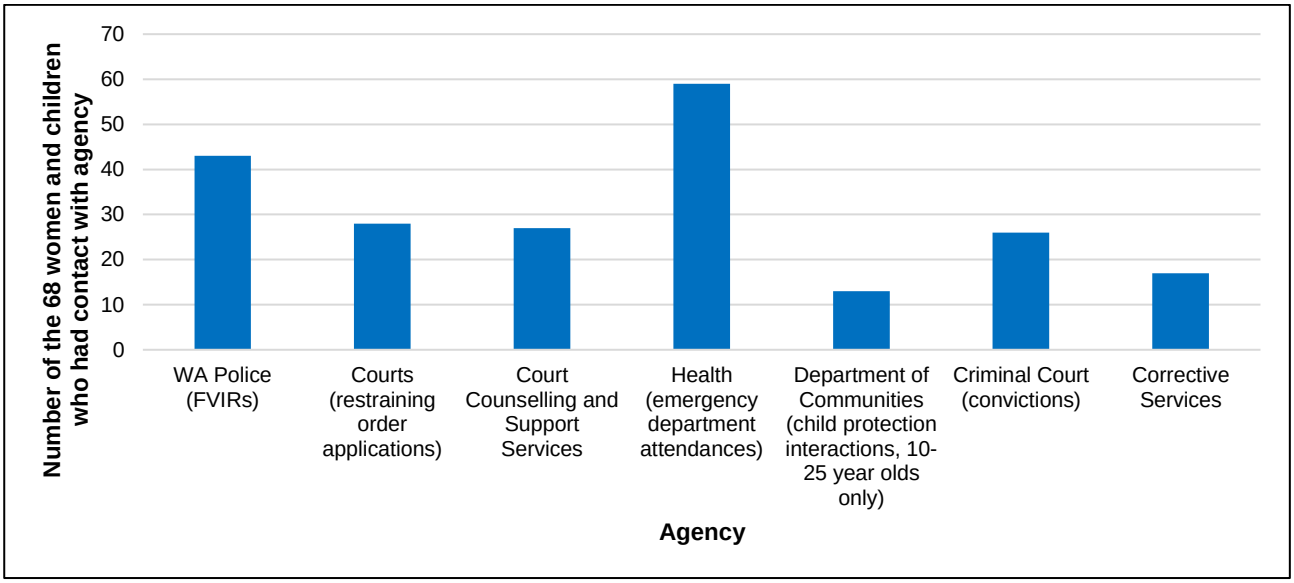
Figure 4: Contact between State government departments and authorities for the 68 women and children



Source: Ombudsman Western Australia

As shown in Figure 5, most of the 68 women and children had contact with the WA Police and emergency departments.

Figure 5: Number of the 68 women and children who had contact with State government departments and authorities, by agency



Source: Ombudsman Western Australia

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3 Contact between the Western Australia Police and the 68 women and children

3.1 Family violence incident reports (FVIRs)

When responding to family and domestic violence, WA Police record what a responding police officer has seen and been told in a family violence incident report (**FVIR**).

The Office obtained data from WA Police relating to FVIRs in which the 68 women and children who died by suicide were named as a victim or person of interest. The earliest recorded FVIRs relating to those who died by suicide took place in 2003, with WA Police informing the Office that this was due to changes in their information recording practices between September 2002 and December 2004, as follows:

> On 16 September 2002 the Incident Management System (IMS) replaced the Offence Information System (OIS) through the Delta Communications and Technology Program, with the two systems running side by side during the implementation period. By 2004, IMS was available across the agency with all OIS data archived in December 2004.[41]

Accordingly, the data regarding contact which follows is based upon the available data from WA Police spanning 14 years of family and domestic violence incident reports (**FVIRs**) from 2003 until the victims' deaths in 2017.

3.1.1 Two-thirds of the 68 women and children who died by suicide had contact with WA Police relating to family and domestic violence

Despite most family and domestic violence going unreported to government services, the Office found that 43 of the 68 women and children had family and domestic violence related contact with WA Police between the introduction of FVIRs in 2003 and their deaths in 2017 (66 per cent).

This finding is consistent with the research literature identifying experiences of family and domestic violence as a significant psycho-social risk factor for suicide.[42]

3.1.2 Thirty-six of the 68 women and children had multiple family and domestic violence related contacts with WA Police

WA Police recorded a total of 520 FVIRs relating to the 43 women and children named in a FVIR by WA Police on one or more occasions prior to their death.

[41] Western Australia Police Force, electronic communication, 27 November 2021.
[42] Dillon et al, 'Mental and Physical Health and Intimate Partner Violence Against Women: A review of the literature', *International Journal of Family Medicine,* 2013, 313909, p. 5; Golding JM, 'Intimate partner violence as a risk factor for mental disorders: A meta-analysis', *Journal of Family Violence,* 1999, vol. 14, p. 99-132; Lipsky S et al, 'Is there a relationship between victim and partner alcohol use during an intimate partner violence event?', *Journal of Studies on Alcoholism*, 2005, 66(3), p. 407-412; Taft A, *Promoting women's mental health: The challenges of intimate/domestic violence against women: Issues Paper 8*, 2003, Australian Domestic Violence Clearinghouse; Devries KM et al, 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', *PLoS Medicine*, 2013, 10(5), e1001439; Devries KM et al, 'Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women', *Social Science & Medicine*, 2011, 73(1) p. 79-86; Garcia-Moreno C et al, 'Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence', *The Lancet*, 2006, 368(9543), p. 1260-1269; MacIsaac MB et al, 'The association between exposure to interpersonal violence and suicide among women: a systematic review', *Australian and New Zealand Journal of Public Health*, 2017, 41(1) p. 61-69.

The number of FVIRs relating to each woman and child ranged from one to 54, with an average of 12 FVIRs per person and a median of four.

Thirty-six of the women and children who died by suicide (84 per cent) had more than one occasion of family and domestic violence related contact with WA Police. Of these 36 women and children with multiple recorded occasions of family and domestic violence related contact with WA Police, 16 had more than 10 contacts (44 per cent).

3.2 WA Police identification of women and children as victims of family and domestic violence

3.2.1 Forty-one of the 43 women and children known to have had family and domestic violence related contact with WA Police were identified as a victim of this violence

During the investigation period, police officers were required to identify the parties to a family and domestic violence incident in a FVIR (where known or suspected), including the:

- **Victim**: a person recorded as the victim of a family and domestic violence incident or offence attended by WA Police;
- **Person of Interest:** a person considered by WA Police to be 'a legitimate subject of inquiry' in relation to an alleged offence, 'but who does not satisfy the criteria in s 128 of the *Criminal Investigation Act 2006* so as to provide a power to arrest;'[43] and
- **Offender**: suspected of having committed a criminal offence during a family and domestic violence incident, as detected by WA Police.

The Office notes that the investigation period was prior to reforms in WA Police investigative procedures that ceased use of the term 'person of interest', which was replaced by use of terms that align with the terms used in the *Criminal Investigation Act 2006* such as 'arrested suspect', 'arrestable suspect' and 'suspect'.[44] Accordingly, in this context, WA Police's identification of 'persons of interest' in FVIRs cannot be interpreted as implying that an individual is suspected of being a perpetrator of family and domestic violence, as noted by the Corruption and Crime Commission in its report on Operation Aviemore:

> When police are investigating a crime and there is no obvious perpetrator, it is an appropriate strategy to consider whether there are persons of interest that can be either implicated or eliminated. There may be no reasonable suspicion that a POI [person of interest] might be an offender until further investigation is carried out.[45]

Rather, at the time these FVIRs were written, the term 'person of interest' potentially included 'both witnesses and suspects' to an offence.[46]

[43] Government of Western Australia, *Statutory Review of the Criminal Investigation Act 2006: Issues Paper,* January 2017, p. 148 citing Weldon I, *Criminal Law Western Australia* Looseleaf edition (LexisNexis, Butterworths) at [99,260.10].
[44] Government of Western Australia, *Statutory Review of the Criminal Investigation Act 2006: Final Report*, June 2018, p. 146–147.
[45] Corruption and Crime Commission of Western Australia, *Report on Operation Aviemore: Major Crime Squad Investigation into the Unlawful Killing of Mr Joshua Warneke*, 5 November 2015, p. 43-45.
[46] Aboriginal Legal Service of Western Australia, *Submission to the Statutory Review of the Criminal Investigation Act 2006 (WA)*, 29 March 2017, p. 15.

Forty-one of the 43 women and children known to have had family and domestic violence related contact with WA Police were identified as a victim of this violence in an FVIR. Of the 43 women and children who had family and domestic violence related contact with WA Police prior to their death, 32 (63 per cent) were identified as both a victim and as a person of interest or offender in FVIRs, as shown in Table 4.

The Office's analysis included analysis of FVIRs where a woman or child was identified as a victim of family and domestic violence and a person of interest in a single report.

Table 4: WA Police categorisation of the 43 women and children who experienced family and domestic violence prior to suicide in family and domestic violence incident reports

Identified in FVIRs across WA Police contact	Women and children (n=43)	FVIRs associated with these categorisations of women and children (n=520)
Victim	9 (21%)	14
Person of interest	2 (5%)	6
Victim and person of interest	20 (47%)	210
Victim and offender	1 (2%)	4
Victim, person of interest and offender	11 (26%)	286

Source: Ombudsman Western Australia

3.2.2 Twelve women among the 43 women and children known to have had family and domestic violence related contact with WA Police were also recorded as a suspected offender in FVIRs

As discussed in Volume 2, the research literature observes that women are often misidentified as perpetrators of family and domestic violence due to system abuse by perpetrators and 'misperceptions of victim behaviour, perpetrator manipulation of police and legal systems, and incident-based policing in a civil law context that requires investigation of a pattern of coercive control.'[47]

Table 4 shows that 12 women among the 43 women and children known to have had family and domestic violence related contact with WA Police were also recorded as a suspected offender in an FVIR.

[47] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 34.

The Office also considered data on police orders issued by WA Police as recorded in FVIRs. A police order is an order made by a police officer under Part 2 Division 3A of the *Restraining Orders Act 1997*. Police orders are temporary orders that can only be made in circumstances where a police officer reasonably believes that:

- 'a person has committed an act of family and domestic violence and is likely again to commit such an act;'[48] or
- 'a child has been exposed to an act of family and domestic violence … and the child is likely again to be exposed to such an act;'[49] or
- 'a person will have committed against him or her an act of family and domestic violence;'[50] or
- 'a child will be exposed to an act of family and domestic violence … and that making a police order is necessary to ensure the safety of a person.'[51]

Under section 30C of the *Restraining Orders Act 1997*, police may impose any restraint they 'consider appropriate to prevent a person committing family violence' that restrict them from engaging in what would otherwise be lawful behaviours, in order to prevent family and domestic violence,[52] as follows:

> (2) Without limiting the restraints that may be imposed, a police office may restrain a person from doing all or any of the following:
>
> (a) being on or near premises where a person lives or works;
>
> (b) approaching within a specified distance of another person;
>
> (c) causing or allowing another person to engage in conduct of a type referred to in paragraph (a) or (b). …
>
> (3) A restraint may be imposed on a person on such terms as the police officer considers appropriate.
>
> (4) A police order may restrain a person from entering or remaining in a place, or restrict a person's access to a place, even if the person has a legal or equitable right to be at the place.
>
> (5) A police officer making a police order is to ensure that the order made is as least restrictive of the personal rights and liberties of the person to be bound by the order as possible while still ensuring that the person for whose benefit the order is made is protected from acts of abuse. [53]

[48] *Restraining Orders Act 1997* (WA), s. 30A(1)(a)(i); Western Australia, *Parliamentary Debates*, Legislative Assembly, 2 June 2004, p. 3303c-3306a (JA McGinty, Attorney General.).
[49] *Restraining Orders Act 1997* (WA), s. 30A(1)(a)(ii).
[50] *Restraining Orders Act 1997* (WA), s. 30A(1)(b)(i).
[51] *Restraining Orders Act 1997* (WA), s. 30A(1)(b)(ii).
[52] *Restraining Orders Act 1997* (WA), s. 30C(1).
[53] *Restraining Orders Act 1997* (WA), s. 30C(2)-(5).

Persons named in a police order are referred to as the person:

- **Protected:** that is, 'the person or persons for whose benefit the order is made';[54] and
- **Bound:** that is, 'the person on whose lawful activities and behaviour restraints are imposed by the order'.[55]

The Office's analysis of police orders found that WA Police issued a total of 159 police orders in respect of 30 women and three children of the 43 women and children named as a victim in a FVIR, as summarised in the following table:

Table 5: Police orders issued and recorded in a FVIR

Nature of Police Order	Number of women and children (n = 33)	Number of police orders issued (n=159)
Protected by a police order	27	94
Bound by a police order	20	65
Protected and bound by a police order	14	119

Source: Ombudsman Western Australia

Thirteen women and one child were both protected and bound by police orders. Of these 119 police orders:

- 50 orders bound the 13 women and one child; and
- 69 orders protected the 13 women and one child.

Across Australia, the problem of misidentification of women as perpetrators of family and domestic violence is shown in the over-representation of women named as respondents in Restraining Order and equivalent legal proceedings (comprising between one fifth and one quarter of these applications), as compared to reliable data on experiences of family and domestic violence.[56]

Women who do not present to police and other support services in the submissive, passive and cooperative ways depicted in popular culture, including women who use violence in self-defence and those who turn to alcohol or substances in response to the abuse, can be misidentified as suspected perpetrators of abuse, particularly when there are 'mutual allegations of violence.'[57] Accordingly, the analysis in Table 4 showing that twelve women were recorded as both victims and suspected perpetrators of family and domestic violence, is not unexpected and is consistent with the findings of previous Australian research.[58] As noted by the Australia's National Research Organisation for Women's Safety Limited (**ANROWS**):

> Counting instances of physical violence without establishing context has been widely criticised, but the method persists. … There is now a substantial evidence

[54] *Restraining Orders Act 1997* (WA), s. 30E(2)(a).
[55] *Restraining Orders Act 1997* (WA), s. 30E(2)(b).
[56] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, Sydney.
[57] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, Sydney, p. 9.
[58] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, Sydney.

> base from contextual research that women arrested for DFV frequently express different motivations and use violence in different contexts. These differences are not accounted for in a "gender-neutral" application of DFV policies.
>
> … the evidence … indicates that (a) most women who use force against their male intimate partners are themselves battered … (b) there are multiple motivations for using such violence, including self-defense, escaping abuse, and reclaiming a sense of self … and (c) women who use force often suffer punishing consequences for their conduct meted out by their partners and various systems in society.[59]

Throughout this investigation, the Office has sought to use as many sources of information possible in its assessment of women and children as victims of family and domestic violence.

Research on accurately identifying the 'person most in need of protection' acknowledges that '[w]ithout knowledge of the history of the relationship, use of violence against someone who is perpetrating DFV may be misread, and the law will be inappropriately applied.'[60]

ANROWS has recommended that 'clearer guidance and training' and 'changes to policing and investigation models' are needed to assist police in better identifying the person most in need of protection:

> … police need clearer guidance and training to assist them to distinguish between coercive controlling violence (physical and non-physical) and violence used in response to ongoing abuse. Explicit guidance on identifying patterns of coercive control would assist police in identifying the person most in need of protection in ambiguous circumstances, and in determining whether a protection order is necessary or desirable.
>
> The changes to policing and investigation models most widely supported by participants were specialist DFV police units or co-responder models. These models see specialists with expertise in coercive control accompany police at investigations, or otherwise support police assessments. Co-responders were widely seen as potential enablers of good police practice in identifying the aggrieved and respondent, and the appropriate action to be taken. Police participants in particular expressed support for specialist and co-responder models as strategies to improve policing responses. … There was widespread recognition that this would require significant resourcing. However, there may be other ways to achieve some of the benefits of a co-responder model. Police in this research suggested, for example, consultation with a specialist unit to support investigation and decision-making on whether an application is necessary or desirable.[61]

[59] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 19, citing Larance LY, Goodmark L, Miller SL, & Dasgupta SD, 'Understanding and addressing women's use of force in intimate relationships: A retrospective', *Violence Against Women*, 2019, 25(1), 56–80, p. 57, <https://doi. org/10.1177/1077801218815776>.
[60] Australia's National Research Organisation for Women's Safety, *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions (Research to policy and practice, 23/2020)*, 2020, ANROWS, Sydney.
[61] Nancarrow H, Thomas K, Ringland V & Modini T, *Accurately identifying the "person most in need of protection" in domestic and family violence law (Research report, 23/2020)*, 2020, ANROWS, Sydney, p. 19, citing Larance LY, Goodmark L, Miller SL, & Dasgupta SD, 'Understanding and addressing women's use of force in intimate relationships: A retrospective', *Violence Against Women*, 2019, 25(1), 56–80, p. 57, <https://doi. org/10.1177/1077801218815776>.

Recommendation 1 That the Western Australia Police Force implement the recommended policy and practice reform proposed by Australia's National Research Organisation for Women's Safety (**ANROWS**) in its report on *Accurately identifying the "person most in need of protection" in domestic and family violence law*, including the development of guidance on:

- distinguishing between coercive controlling violence (physical and non-physical) and violence used in response to ongoing abuse;
- identifying patterns of coercive control;
- identifying the person most in need of protection in ambiguous circumstances; and
- determining whether a police order is necessary or desirable.

3.2.3 Research observes a strong and consistent association between family and domestic violence and the suicide of women and children, including exploration of the proximity of family and domestic violence to suicide

Researchers have undertaken studies about the time between a family and domestic violence incident to suicide in an effort to ascertain 'the significance of domestic violence for suicide attempts.'[62]

An Australian systemic review conducted in 2012 concluded that:

> With only one exception, all of the studies found a strong and consistent association between intimate partner abuse and suicidality.[63]

Some of the research indicates that physical abuse perpetrated by an intimate partner 'may be the single most important cause of female suicidality.'[64] Other scholars have noted that:

> … one of the important features of battering is that it takes place in a context of many other forms of coercion that isolate and intimidate women and that these features in particular, additional to the physical violence, entrap women and lead to suicide attempts. The temporal closeness between battering and attempted suicide confirms the strong causal link, rather than both being due to something else.[65]

Australian research has also examined the amount of time elapsed between a person's most recent recorded exposure to family and domestic violence and their death by suicide. In its 2015-2017 Annual Report, the NSW Domestic Violence Death Review Team identified that 45 per cent of women who died by suicide in the context of family and domestic violence, relationship breakdown, conflict and/or separation 'had contact with police in relation to domestic and family violence within 12 months of their suicide.'[66]

[62] Walby S, *The Cost of Domestic Violence*, 2004, Women and Equality Unit, London, p. 56.
[63] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, 32(8), p. 677-689.
[64] Walby S, *The Cost of Domestic Violence*, 2004, Women and Equality Unit, London, p. 56.
[65] Walby S, *The Cost of Domestic Violence*, 2004, Women and Equality Unit, London,, p. 56.
[66] NSW Domestic Violence Death Review Team, *NSW Domestic Violence Death Review Team Report 2015-2017*, 2017, New South Wales Government, Sydney, p. 141.

More recently, Queensland's Domestic and Family Violence Death Review and Advisory Board identified that, in over one-third (39 per cent) of all cases where a person who died by suicide had a recorded history of family and domestic violence, the 'violence was known to be escalating [in frequency] in close proximity to the apparent suicide.'[67]

In contrast, researchers using information from the Coroner's Court of Victoria's Suicide Register identified that almost half of women who died by suicide had a 'history of exposure to IPV [inter-personal violence]' however their 'most recent experience of violence … was often more than 12 months prior to suicide.'[68]

3.2.4 Twenty-five of the 43 women and children known to WA Police had been named in a FVIR within 12 months of their death (58 per cent)

This investigation examines the time between the 43 women and children's most recent family and domestic violence related contact with WA Police prior to their suicide. The Office's analysis aims to contribute to a deeper understanding of the opportunities for enhanced recognition and responses to suicide risk for women and children with experiences of family and domestic violence.

For the 43 women and children known to WA Police, the Office analysed the time elapsed between the most recent reported FVIR and their death by suicide.

Table 6: Time between final FVIR and suicide, for the 43 women and children known to WA Police

Time from most proximal FVIR to suicide	Women and children (n=43)
Less than one month	6 (14%)
1 to 3 months	11 (26%)
4 to 6 months	4 (9%)
7 to 12 months	4 (9%)
1 to 2 years	6 (14%)
2 to 5 years	5 (12%)
5 to 10 years	4 (9%)
More than 10 years	3 (7%)

Source: Ombudsman Western Australia

Arising from this analysis, the Office identified that, for the 43 women and children known to have experienced family and domestic violence prior to their suicide and had contact with WA Police regarding this violence, 21 had an FVIR in the six months prior to their death (49 per cent).

As identified in Table 6, five women and one child died within one month of the last FVIR recorded by WA Police. All had their last contact with WA Police regarding family and domestic violence within a week of their death.

[67] Domestic and Family Violence Death Review and Advisory Board, *Domestic and Family Violence Death Review and Advisory Board 2019-2020 Annual Report*, 2021, Queensland Government, Brisbane, p. 43.
[68] MacIsaac, M. Bujega, L. Weiland, Selvakumar, K. and Jelinek, G. 'Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia,' *Asia Pacific Journal of Public Health,* 2018, 30(1), p. 40.

3.2.5 Contact with WA Police by age and Aboriginality

The Office compared the frequency of family and domestic violence related contact with WA Police for Aboriginal and/or Torres Strait Islander women and children, and children and young women aged 25 or under against the total WA Police contact for the 68 women and children who died by suicide (Table 7 and Table 8)

Table 7: Frequency of contact with WA Police as recorded in FVIRs for the 68 women and children, by Aboriginal and/or Torres Strait Islander status and age

	ATSI status		Age	Total	
	ATSI (n=12)	Non-ATSI (n=56)	Children and young women aged 10 to 25 years (n=20)	Women aged 26 years and over (n=48)	Women and children (n=68)
Any contact with WA Police regarding family and domestic violence	12 (100%)	32 (59%)	9 (69%)	31 (65%)	43 (66%)
Multiple WA Police FVIRs	10 (83%)	24 (44%)	8 (62%)	26 (50%)	34 (52%)
Persistent contact with WA Police (more than 10 FVIRs)	7 (58%)	9 (17%)	3 (23%)	13 (25%)	16 (25%)

Source: Ombudsman Western Australia

Table 8: Proximity between death and last contact with WA Police for the 43 women and children named in one or more recorded FVIRs during the investigation period, by Aboriginal and/or Torres Strait Islander status and age

	ATSI status		Age		Total
	ATSI (n=12)	Non-ATSI (n=32)	Children and young women aged 10 to 25 years (n=9)	Adults aged 26 years and over (n=31)	Women and children (n=43)
FVIR within 1 month of their death)	4 (33%)	7 (22%)	5 (56%)	6 (19%)	11 (26%)
FVIR within 3 months of their death	6 (50%)	11 (34%)	8 (89%)	9 (29%)	17 (40%)
FVIR within 6 months of their death	9 (75%)	12 (38%)	8 (89%)	13 (42%)	21 (49%)
FVIR within 12 months of their death	9 (75%)	15 (47%)	8 (89%)	16 (52%)	24 (56%)

Source: Ombudsman Western Australia

3.2.6 All of the 12 Aboriginal and/or Torres Strait Islander women and children who died by suicide following experiences of family and domestic violence had contact with WA Police about their experiences of family and domestic violence

The Office also separately compared WA Police data about the experiences of family and domestic violence for the women and children who died by suicide that were:

- Aboriginal and/or Torres Strait Islander (12 women and children); and
- children and young women aged 25 years or younger at the time of their death (20 women and children).

The Office identified that all of the 12 Aboriginal and/or Torres Strait Islander women and children who died by suicide had contact with WA Police regarding their experiences of family and domestic violence, compared to 65 per cent (31) of the 56 non-Aboriginal women and children who died.

Additionally, the Office identified that the 20 children and young women aged 25 years or younger at the time of their death had contact with WA Police regarding their experiences of family and domestic violence at a similar rate to women aged 26 years and older, with:

- nine of the 20 children and young women aged 25 years and younger identified in one or more FVIRs (69 per cent); and
- 31 of the 48 women aged 26 years and older identified in one or more FVIRs (65 per cent).

4 Use of restraining orders by the 59 women who died by suicide

4.1 The Office received data from several Western Australian courts and specialist tribunals

In undertaking the investigation, the Office requested information about the 68 women and children from several Western Australian Courts and specialist tribunals, including:

- identified data about the 59 women from the Magistrates Court of WA, the District Court of WA, and the Supreme Court of WA; and
- de-identified data about the 9 children from the Children's Court of WA and the Office of Criminal Injuries Compensation.

The Office undertook detailed analysis of the identified data provided, relating to the 59 women who died by suicide and their use of restraining orders.

4.2 The use of restraining orders by the 59 women

On 1 July 2017, arising from the *Restraining Orders and Related Legislation Amendment (Family Violence) Bill 2016*, significant amendments to the *Restraining Orders Act 1997* came into effect with the aim of making the civil restraining orders regime 'more responsive to the particular issues associated with family violence.' These reforms aimed:

> … to increase safety for victims of family violence, and strengthen integrated, accountable and effective interventions targeting perpetrators of family violence and abuse.[69]

As a result of the reforms, Family Violence Restraining Orders (**FVROs**) were established under Part 1B of the *Restraining Orders Act 1997*, and are supported by principles and definitions, 'all of which promote a contemporary understanding of the nature and seriousness of family violence.' Further, Violence Restraining Orders (**VROs**) 'are retained for use in cases of personal violence,' but not for people in a family relationship. Misconduct Restraining Orders (**MROs**) 'are also retained' and continue to be used 'for people not in a family relationship where intimidating or offensive, but not violent, behaviour has occurred.'[70]

The Office examined patterns and trends about the use of restraining orders among the 59 women. This information is useful in learning about occasions when women and children affected by family and domestic violence took action to protect themselves from family and domestic violence.

The Office analysed where the 59 women were a protected person, and/or a person bound by a restraining order.

[69] Explanatory Memorandum, Restraining Orders and Related Legislation Amendment (Family Violence) Bill 2016 (WA).
[70] Explanatory Memorandum, Restraining Orders and Related Legislation Amendment (Family Violence) Bill 2016 (WA).

4.2.1 Twenty-eight of the 59 women were involved in proceedings for a restraining order prior to their death (47 per cent)

The Office identified that 28 of the 59 women were involved in restraining order proceedings prior to their death (47 per cent). These 28 women were identified in a cumulative total of 85 distinct restraining order applications (Table 9).

Table 9: Number of applications for a restraining order, by type of order, for the 28 women that were involved in restraining order proceedings

Type of restraining order	Number of women, noting that a person may apply for and be granted multiple forms of restraining order (n=28)	Number of restraining order applications (n=85)
Violence Restraining Order	26	81
Misconduct Restraining Order	1	2
Restraining Order	1	1
Family Violence Restraining Orders	1	1

Source: Ombudsman Western Australia

The Office also identified that 19 women had been involved in restraining order proceedings on multiple occasions as shown in Table 10.

Table 10: Number of restraining orders, for the 28 women that were involved in restraining order proceedings

Number of restraining orders	Women (n=28)
1	10
2	7
3	5
4	0
5 or more	6

Source: Ombudsman Western Australia

The Office's analysis shows that one fifth of the 28 women that were involved in restraining order proceedings (six women or 21 per cent) were involved in proceedings relating to five or more separate restraining order applications.

4.2.2 Twenty-four of the 28 of women and children named in a restraining order prior to their suicide, were named as a protected person (86 per cent)

The Office undertook further analysis to ascertain the status of each woman with respect to the restraining orders they were named in. Of the 28 women that were named in a restraining order, 24 were named as a protected person (86 per cent) (Table 11).

Table 11: Women identified as applicants, protected persons, and respondents in restraining order proceedings

Identified in a restraining order	Women (n=28)
Applicant	20
Protected person	24
Respondent	13

Source: Ombudsman Western Australia

The Office examined the time between the date on which the most recent restraining order naming them was made for each of the 28 women, and their death by suicide.

Eighteen of the 28 women for whom a restraining order was made, were named as a protected person in the last restraining order made prior to their suicide (62 per cent). Five of these women (17 per cent) had a restraining order naming them as a protected person made within two years of their suicide, which is likely to have been current at the time of their death. Three women were named as the respondent in a restraining order made within two years prior to their death.

4.3 The use of restraining orders by the 7 Aboriginal and/or Torres Strait Islander women

4.3.1 All of the seven Aboriginal and/or Torres Strait Islander women were named in a restraining order prior to their death (100 per cent)

Of the seven Aboriginal and/or Torres Strait Islander women among the 59 women, the Office identified that each (100 per cent) had been the subject of a restraining order at some time prior to their death. These seven women were named in 12 restraining orders.

4.3.2 All of the seven Aboriginal and Torres Strait Islander women named in a restraining order were named as a protected person in one or more restraining orders

The Office undertook further analysis to ascertain the status of each woman with respect to the restraining orders they were named in. Each of the seven Aboriginal and/or Torres Strait Islander women were named as a protected person in restraining order proceedings prior to their death (100 per cent).

Table 12: Aboriginal and/or Torres Strait Islander women and children identified as applicants, protected persons, and respondents in a restraining order

Identified in a restraining order	Women (n=7)
Applicant	7
Protected person	7
Respondent	3

Source: Ombudsman Western Australia

Table 13: Number of restraining orders where the 7 Aboriginal and/or Torres Strait Islander women were identified as an applicant, protected person, or respondent

Number of restraining orders where the woman or child was identified as an applicant, protected person, or respondent	Applicant	Protected Person	Respondent
1	3	3	2
2	1	2	1
3	0	1	0
4	0	0	0
5 or more	3	1	0

Source: Ombudsman Western Australia

Arising from this analysis, the Office identified that for the seven Aboriginal and/or Torres Strait Islander women named in a restraining order prior to their death:

- four were protected by multiple restraining orders; and
- three were identified as a respondent in one or more restraining orders.

4.3.3 None of the seven Aboriginal and/or Torres Strait Islander women named in a restraining order prior to their death, was likely to have been protected by a restraining order at the time of their death

The Office examined the most recent date on which the seven Aboriginal and/or Torres Strait Islander women were named in a restraining order. All of the restraining orders for these women had been made more than two years prior to their death. Accordingly, none of the seven women were likely to have been protected by a restraining order at the time of their death.

5 Contact between court counselling and support services, criminal courts and corrective services and the 68 women and children

5.1 Population data and the research literature highlight criminal court proceedings and corrective services contact as a risk factor for suicide

The Australian Bureau of Statistics (**ABS**) examines 'associated causes' when referring to conditions other than the underlying cause of death and identifies that 'associated causes can include diseases that are part of the chain of events leading to death, risk factors and co-morbid conditions.'[71]

The ABS identifies that 'associated causes of death were identified for 90% of suicides' in Australia, and notes that 'problems related to legal circumstances' were relevant for 9.9 per cent of those who died by suicide in 2019.[72] According to a framework derived from the World Health Organisation's Statistical Classification of Diseases (10th Revision), 'problems related to legal circumstances' include:

- conviction in civil and criminal proceedings without imprisonment;
- imprisonment and other incarceration;
- problems related to release from prison;
- problems related to other legal circumstances, including:
- Domestic Violence Orders;
- child custody or support proceedings;
- litigation;
- Restraining Orders;
- potential or impending legal circumstances or court appearances; and
- charges have been laid, awaiting/anticipation of commencement court proceedings.[73]

The research literature also identifies that social stressors can be a significant and proximal risk factor to suicide, including 'facing legal difficulties'.[74] Examining the emotional dynamics of court settings, researchers identify that 'the courtroom is the location of many emotions, usually negative,'[75] noting that:

> In criminal cases, defendants may be fearful or hostile, while victims are distressed or angry. In civil matters, both plaintiffs and respondents may feel frustrated and annoyed at having to go to court. In debt collection cases, defendants may feel embarrassed about their inability to manage their finances. In domestic violence cases, one party may be frightened, or both parties may be

[71] Australian Bureau of Statistics, *Associated causes of death in mortality, 2020*, viewed 26 November 2021, <https://www.abs.gov.au/articles/associated-causes-death-mortality#associated-causes-for-suicides>.
[72] Australian Bureau of Statistics, *Associated causes of death in mortality*, *2020*, viewed 26 November 2021, <https://www.abs.gov.au/articles/associated-causes-death-mortality#associated-causes-for-suicides>.
[73] Australian Bureau of Statistics, *Psychosocial risk factors as they relate to coroner-referred deaths in Australia,* 2019, viewed 26 November 2021, <https://www.abs.gov.au/statistics/research/psychosocial-risk-factors-they-relate-coroner-referred-deaths-australia#annex-listing-psychosocial-codes-inclusions-and-exclusions->.
[74] Fehling KB and Selby EA 'Suicide in the DSM-5: Current Evidence for the Proposed Suicide Behavior Disorder and Other Possible Improvements,' *Frontiers in Psychiatry*, 2021, 11:4999980, doi: 10.3389/fpsyt.2020.499980.
[75] Anleu SR and Mack K, 'Magistrates' Everyday Work and Emotional Labour,' *Journal of Law and Society*, 2005, 32(4), 590-614, p. 591, <https://dx.doi.org/10.1111/j.1467-6478.2005.00339.x>.

> openly hostile. Court users can feel intimidated, experiencing both fear and uncertainty, which can affect emotional displays.[76]

Research also examines the court process for those affected by family and domestic violence. For Aboriginal and Torres Strait Islander women and children in particular:

> Court experiences are marked by high levels of public scrutiny and shame, lack of access to information, lack of opportunity to participate fully in processes and decision making, and risk of being subjected to blame, discrimination and reprisal.[77]

Policy frameworks in some Australian jurisdictions explicitly highlight court dates as a risk factor for suicide and include this in assessment protocols. The NSW Department of Health's *Suicide Risk Assessment and Management Protocols* highlights that court appearances are a 'major impending stressor,' for inclusion in suicide risk assessments.[78]

The significance of court dates is also recognised in the Victorian MARAM Framework which provides guidance 'for professionals working with child or adult victim survivors, and adults using family violence', and constitutes a system wide approach to risk assessment and risk management for 'organisations across the many parts of the social service system.'[79]

The MARAM Framework identifies that 'impending court hearings [are a] highly dynamic' risk factor in the context of family and domestic violence, and are relevant when assessing 'risk presented by a person using family violence towards an adult or child victim survivor.'[80]

The MARAM Framework also explicitly identifies that court proceedings are important to consider in the context of suicide risk:

> Suicide risk is likely higher at the time of, or directly after, situational stressors occur, and/or if a change within the person's life involves a loss of control or power.
>
> Situations include: removal from the home, when paperwork is served (following a family violence notification – either a 'caution' or a family violence intervention order), when a court report is handed down, leading up to court appearance, family court and parenting orders (that result in loss of/reduced access to children).
>
> People in contact with the legal system, including with police, courts and corrections, are at higher suicide risk. This risk has been found to increase with 'recency' and 'frequency' of contact.[81]

[76] Anleu SR and Mack K, 'Magistrates' Everyday Work and Emotional Labour,' *Journal of Law and Society*, 2005, 32(4), 590-614, p. 591, <https://dx.doi.org/10.1111/j.1467-6478.2005.00339.x>.
[77] Moore E, *Not Just Court: Indigenous Families, Violence And Apprehended Violence Orders In Rural New South Wales*, 2002, University of Sydney, p. 8.
[78] NSW Department of Health, *Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit,* 2004, p. 3.
[79] Family Safety Victoria, *MARAM Practice Guides – Foundation Knowledge Guide*, 2021, Victorian Government, p. 3, viewed 23 November 2021, <https://www.vic.gov.au/maram-practice-guides-and-resources>.
[80] Family Safety Victoria, *MARAM Practice Guides – Foundation Knowledge Guide*, 2021, Victorian Government, p. 55, viewed 23 November 2021 <https://www.vic.gov.au/maram-practice-guides-and-resources>.
[81] Family Safety Victoria, *MARAM Practice Guides – Foundation Knowledge Guide*, 2021, Victorian Government, p. 126, viewed 23 November 2021 <https://www.vic.gov.au/maram-practice-guides-and-resources>.

Researchers also highlight that the period following arrest can be particularly dangerous for a person, noting that 'more attention should be paid to reducing suicide following criminal arrest.'[82] For those in custody, research has identified that the interval immediately after arrest is 'associated with a particularly high rate of suicide,' with a further study highlighting that 'recent arrest status is associated with higher prevalence of suicide attempts than parole, probation, or no involvement with the criminal justice system.'[83]

The *Western Australian Suicide Prevention Framework 2021-2025* highlights that 'many services and agencies which do not have suicide prevention as part of their core business may not recognise they are engaged with some of the most vulnerable members of the community. They have an important role in identifying and responding to those who may be vulnerable to suicidal behaviour due to risk factors such as financial hardship, relationship loss, historic and current trauma**,** legal issues, and social isolation.'[84]

5.2 Contact between court counselling and support services and the 68 women and children prior to their suicide

5.2.1 The Department of Justice's Court and Tribunal Services division

The Department of Justice provides counselling and support services to victims of crime through its Court Counselling and Support Services directorate. In this context, 'victims of crime' includes those who 'suffer injury or loss as a direct result of an offence or [who] … are a member of the immediate family where an offence results in the death of an individual.'[85]

The Department of Justice offers a range of services offering advocacy and support to victims of crime in Western Australia, including:

- Child Witness Service;
- Family Violence Service;
- Victim Support Service; and
- regionally based Victim Support and Child Witness Service.

The Department of Justice's Court and Tribunal Services directorate further informed the Office during this investigation that:

> All clients are voluntary, and each Service has qualified staff who are available for victims of crime, child witnesses and/or family violence victims. The service delivery includes a range of support options such as clinical counselling, court updates, court preparation, court support, intensive support and liaison with/referral to other agencies.
>
> In addition, the directorate supports the principles of trauma informed practice and the staff are trained and experienced in delivering trauma informed support. The directorate aims to respond to and support clients based on their specific needs and circumstances, ensure all clients are aware of their rights and

[82] Piel J, 'Suicide Risk Following Criminal Arrest,' *Psychiatric Times*, 31 December 2020, viewed 26 November 2021 <https://www.psychiatrictimes.com/view/suicide-risk-following-criminal-arrest>.
[83] Piel J, 'Suicide Risk Following Criminal Arrest,' *Psychiatric Times*, 31 December 2020, viewed 26 November 2021 <https://www.psychiatrictimes.com/view/suicide-risk-following-criminal-arrest>.
[84] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, Government of Western Australia, Perth, p. 43.
[85] Government of Western Australia, *Court Counselling and Support Services*, viewed 28 May 2022, <https://www.wa.gov.au/service/community-services/counselling-services/court-counselling-and-support-services>.

opportunities, encourage clients to make their own decisions, and support clients who know what to do or where to go without the need for assistance. The directorate is focussed on assisting clients to build empowerment, confidence and independence. Any support or assistance provided by the directorate is based on the client's wishes to engage and receive this formal support.

5.2.2 Court counselling and support services client data obtained during the Investigation

The Office obtained client data for the women and children who died by suicide from the Department of Justice's Court Counselling and Support Services directorate, including the:

- name of the branch which delivered the service;
- timeframe of involvement; and
- type of service delivered in each session.

This data did not include case notes or additional details about the context of the Department of Justice's Court Counselling and Support Services directorate's involvement with the women and children who died by suicide.

The Office undertook analysis to identify how many of the women and children who died by suicide were supported by services provided by the Department of Justice's Court Counselling and Support Services directorate.

Based on data provided by the Department of Justice, the Office identified that 27 of the 68 women and children had contact with Court Counselling and Support Services prior to their death (40 per cent) on 411 occasions.

The Office also considered the range of services provided to the 27 women and children, and the frequency of contact with court counselling and tribunal services, as shown in Table 14.

Table 14: Contact between the Department of Justice's Court Counselling and Support Services directorate and 27 women and children known to have been a victim of crime

Type of court counselling and support service provided	Number of women and children (n=27)	Number of occasions (n=411)
Advocacy	1	2
Agency Liaison	9	78
Assessment	3	11
C.I.C. Assist	2	4
Client Support Post Court	1	3
Counsel ind Session 1	1	1
Court Support Co-ordination	1	4
Court Support-VSW	1	1
Debrief Individual	3	9
FOH Court Support	1	2
Info	1	1
Info Court	12	61
Info General	8	40
Info Police	6	16
Info Safety	4	25
Info Sentence	2	6
Info Services	8	17
Intensive Supp/Debrief	1	7
Offer of Service	20	41
PLO Volunteer Follow up	1	2
Referral	1	1
Referral From	3	15
Referral to	1	2
Referral to - Legal Service	1	1
Referral to - Other	1	1
Risk Assess/Safety Plan.	3	4
Risk assessment	2	5
Special Witness Assessmt	1	3
V.I.S. Assist	2	7
Vol - Phone Follow Up	1	2
Vol Support-court	1	2
VRO - Court Support/Debrief	1	1
VRO Court Preparation	2	3
VRO Ex-Parte - Adult	2	2
VRO Exparte Application	7	17
VRO Information	3	7
VRO Information - Outcomes	2	3
VRO Information - Process	2	2
Witness Preparation - Vol	1	2

Source: Ombudsman Western Australia

The number of contacts per person ranged from one to 81, with an average of 15.

Three women had only one contact with Court Counselling and Support Services in the form of an 'offer of service letter' and then did not seek or wish for further support relating to their experience as a victim of crime.

The majority of contacts recorded (292 contacts) involved direct contact with the client, while 119 contacts involved an offer of service letter (41 contacts) or liaison with another service provider (78 contacts).

The Office also considered the proximity of Court Counselling and Support Services contact to the client's death by suicide. The Office found that 6 individuals (22% of the 27 women and children who experienced family and domestic violence prior to their death and were known to be a victim of crime) had direct contact with Court Counselling and Support Services within one year of their death on 27 recorded occasions. This included:

- three people with contact between six and 12 months prior to their death;
- one person with contact between three and 6 months of their death; and
- two people who had contact within three months of their death (on 11 occasions).

5.3 Contact between criminal courts and the 59 women who died by suicide

5.3.1 The Office analysed offences by Australian and New Zealand Standard Offence Classification division type

The Australian and New Zealand Standard Offence Classification (**ANZSOC**) is a framework classifying criminal behaviour and is utilised in Australia and New Zealand for the production and analysis of crime and justice statistics.

In Australia, the ANZSOC is used in Australian Bureau of Statistics statistical collections, by WA Police, criminal courts and corrective services agencies to provide a 'standardised statistical framework for organising key behavioural characteristics of criminal offences, and to overcome differences in legal offence definitions across states and territories.'[86]

The ANZSOC is a classification with three levels including 'Divisions (the broadest level), Subdivisions (the intermediate level) and Groups (the finest level). At the divisional level, the main purpose is to provide a limited number of categories that provide a broad overall picture of offence types, that are suitable for the publication of summary tables in official statistics.'[87]

[86] Australian Bureau of Statistics, *Australian and New Zealand Standard Offence Classification (ANZSOC)*, 2011, viewed 18 November 2021 <https://www.abs.gov.au/ausstats/abs@.nsf/mf/1234.0>.
[87] Australian Bureau of Statistics, *Australian and New Zealand Standard Offence Classification (ANZSOC)*, 2011, viewed 18 November 2021 <https://www.abs.gov.au/ausstats/abs@.nsf/mf/1234.0>.

The 16 divisional titles outlined in the structure for the third edition of the ANZSOC include:

01 Homicide and related offences
02 Acts intended to cause injury
03 Sexual assault and related offences
04 Dangerous or negligent acts endangering persons
05 Abduction, harassment and other offences against the person
06 Robbery, extortion and related offences
07 Unlawful entry with intent/burglary, break and enter
08 Theft and related offences
09 Fraud, deception and related offences
10 Illicit drug offences
11 Prohibited and regulated weapons and explosives offences
12 Property damage and environmental pollution
13 Public order offences
14 Traffic and vehicle regulatory offences
15 Offences against government procedures, government security and government operations
16 Miscellaneous offences[88]

The Office analysed criminal convictions for the women and children who died by suicide using the relevant ANZSOC divisions, subdivisions and groups associated with each offence within the data obtained from the Magistrates Court, District Court and Supreme Court.

5.3.2 Forty-four per cent of the 59 women were convicted of a criminal offence (26 women)

The Office analysed identified court data to identify how many of the women and children who died by suicide were charged or convicted of a criminal offence. As identifiable data from the Magistrates Court of WA, the District Court of WA, and the Supreme Court of WA concerned criminal offences relating only to adult matters, the Office undertook this analysis for the 59 women who were aged 18 years or older at the time of their death.

Based on data from the Magistrates Court, District Court and Supreme Court, the Office identified that 27 of the 59 women (46 per cent) were charged with a criminal offence during their adulthood. Of these 27 women, 26 were subsequently convicted of one or more criminal offences as an adult.

5.3.3 Sixty-six per cent of the convictions for the 26 women convicted of a criminal offence, were for traffic and vehicle regulatory offences, offences against government procedures, government security and government operations and public order offences

The Office analysed criminal offence convictions for the 26 women known to have experienced family and domestic violence prior to their suicide and were convicted of a criminal offence using the ANZSOC divisions, subdivisions and groups (Table 15).

[88] Australian Bureau of Statistics, *Australian and New Zealand Standard Offence Classification (ANZSOC)*, 2011, viewed 18 November 2021 <https://www.abs.gov.au/ausstats/abs@.nsf/mf/1234.0>.

The 26 women were convicted on 356 occasions, with the majority of these convictions being recorded in relation to traffic and vehicle regulatory offences, offences against government procedures, government security and government operations and public order offences (236 convictions, 66 per cent of the 356 convictions).

Nine women were convicted of offences relating to acts intended to cause injury (16 convictions) and 11 women were convicted of illicit drug offences (37 convictions).

Table 15: Adult criminal convictions, by ANZSOC offence division for the 26 women convicted of a criminal offence

ANZSOC offence classification division	Number of women convicted (n=26)	Number of convictions (n=356)
01 Homicide and related offences	0	0
02 Acts intended to cause injury	9	16
03 Sexual assault and related offences	0	0
04 Dangerous or negligent acts endangering persons	3	3
05 Abduction, harassment and other offences against the person	2	2
06 Robbery, extortion and related offences	2	2
07 Unlawful entry with intent/burglary, break and enter	3	3
08 Theft and related offences	13	33
09 Fraud, deception and related offences	7	8
10 Illicit drug offences	11	37
11 Prohibited and regulated weapons and explosives offences	4	7
12 Property damage and environmental pollution	7	9
13 Public order offences	13	22
14 Traffic and vehicle regulatory offences	20	121
15 Offences against government procedures, government security and government operations	13	93
16 Miscellaneous offences	0	0

Source: Ombudsman Western Australia

The Office also considered the convictions of the 26 women by ANZSOC subdivision, as shown in Table 16. The ANZSOC subdivision analysis highlighted in further detail that the women were most frequently convicted of driver licence offences (16 women, 77 convictions), breaches of community based orders (10 women, 61 convictions), theft (excluding motor vehicles) (12 women, 25 convictions), disorderly conduct (11 women, 19 convictions), and regulatory driving offences (11 women, 22 convictions).

Table 16: Adult criminal convictions, by ANZSOC offence subdivision for the 26 women convicted of an offence

ANZSOC Group Code	Description of offence	Number of women convicted (n=26)	Number of convictions (n=357)
021	Assault	9	16
041	Dangerous or negligent operation of a vehicle	3	3
053	Harassment and threatening behaviour	2	2
061	Robbery	2	2
071	Unlawful entry with intent/burglary, break and enter	3	3
081	Motor vehicle theft and related offences	1	2
082	Theft (except motor vehicles)	12	25
083	Receive or handle proceeds of crime	5	6
091	Obtain benefit by deception	6	7
099	Other fraud and deception offences	1	1
103	Manufacture or cultivate illicit drugs	3	3
104	Possess and/or use illicit drugs	9	21
109	Other illicit drug offences	8	13
111	Prohibited weapons/explosives offences	3	6
112	Regulated weapons/explosives offences	1	1
121	Property damage	7	9
131	Disorderly conduct	11	19
132	Disorderly conduct, nec	2	2
133	Offensive conduct	1	1
141	Driver Licence offences	16	77
142	Vehicle registration and roadworthiness offences	9	22
143	Regulatory driving offences	11	22
152	Breach of community-based orders	10	61
153	Breach of violence and non-violence orders	7	19
154	Offences against government operations	3	3
156	Offences against justice procedures	5	10

Source: Ombudsman Western Australia

Further, the Office also considered the frequency of convictions for the 26 women by ANZSOC Group codes. This analysis identified more particularly that the 26 women were most frequently convicted of offences for driving while licence disqualified or suspended (11 women, 48 convictions), breaches of bail (10 women, 32 convictions), breaches of community-based orders (five women, 29 convictions), theft excluding motor vehicles (12 women, 25 convictions) and motor vehicle registration offences (nine women, 22 convictions).

Consistent with WA Police FVIR data and records, the Office's analysis of the convictions for the 26 women also identified that seven women were convicted of breaching a violence order on 19 occasions. Each of these convictions occurred after a guilty plea by the defendant.

Table 17: Adult criminal convictions, by ANZSOC offence group for the 26 women convicted of an offence

ANZSOC Group Code	Description of offence	Number of women convicted (n=26)	Number of convictions (n=357)
0211	Serious assault resulting in injury	2	2
0212	Serious assault not resulting in injury	8	11
0213	Common assault	2	3
0411	Driving under the influence of alcohol or other substance	1	1
0412	Dangerous or negligent operation (driving) of a vehicle	2	2
0532	Threatening behaviour	2	2
0611	Aggravated robbery	1	1
0612	Non-aggravated robbery	1	1
0711	Unlawful entry with intent/burglary, break and enter	3	3
0811	Theft of a motor vehicle	1	2
0829	Theft (except motor vehicles), nec	12	25
0831	Receive or handle proceeds of crime	5	6
0911	Obtain benefit by deception	6	7
0999	Other fraud and deception offences, nec	1	1
1032	Cultivate illicit drugs	3	3
1041	Possess illicit drugs	9	21
1099	Other illicit drug offences, nec	8	13
1112	Sell, possess and/or use prohibited weapons/explosives	3	6
1121	Unlawfully obtain or possess regulated weapons/explosives	1	1
1219	Property damage, nec	7	9
1311	Trespass	2	2
1312	Criminal intent	2	2
1319	Disorderly conduct, nec	9	15
1322	Liquor and tobacco offences	1	1
1329	Regulated public order offences, nec	1	1
1332	Offensive behaviour	1	1
1411	Drive while licence disqualified or suspended	11	48
1412	Drive without a licence	8	18
1419	Driver licence offences, nec	4	11
1421	Registration offences	9	22
1431	Exceed the prescribed content of alcohol or other substance limit	7	9
1432	Exceed the legal speed limit	2	6
1439	Regulatory driving offences, nec	5	7
1523	Breach of bail	10	32
1529	Breach of community-based order, nec	5	29
1531	Breach of violence order	7	19
1541	Resist or hinder government official (excluding police officer, justice official or government security officer)	1	1
1549	Offences against government operations, nec	2	2
1562	Resist or hinder police officer or justice official	4	9
1569	Offences against justice procedures, nec	1	1

Source: Ombudsman Western Australia

5.3.4 None of the 26 women convicted of a criminal offence were convicted of homicide or sexual assault

As shown in (Table 15), none of the 26 women known to have experienced family and domestic violence prior to their suicide with criminal convictions were convicted of homicide or sexual assault.

The Office's analysis shows that in general, women known to have experienced family and domestic violence prior to suicide are rarely convicted of acts intended to cause injury, dangerous or negligent acts endangering persons, and abduction, harassment and other offences against the person. These ANZSOC divisions, cumulatively, accounted for 21 of the 356 convictions recorded against the 26 women known to have experienced family and domestic violence prior to their suicide and convicted of a criminal offence (six per cent of convictions).

5.3.5 Western Australian courts provide court-based forensic mental health services, and specialist courts operate with the aim of providing specific assessments and interventions related to mental health, intellectual disability, and other needs

The Western Australian Mental Health Court Liaison Service is a service offered by the Department of Health's State Forensic Mental Health Service (**SFMHS**). SFMHS provides a court liaison service to all Courts in Western Australia, including in person to Central Law Courts, and via videoconference to other Metropolitan and Regional Courts:

> Court liaison mental health services aim to provide mental health advice, assessments, referral and diversion for people who have been charged with an offence. These services intervene early in the criminal justice process at the post arrest and pre-sentence stages. Court liaison services are responsible for seeking out individuals already within the court system who may require mental health services. This may entail reviewing court lists for individuals who are already known to mental health services and/or attending court and making the service known to consumers and families.
>
> Court liaison services:
>
> - Conduct mental health assessments and may intervene to link individuals to mental health service providers.
> - Provide or facilitate specialised advice to the court regarding the impact of a person's mental health or intellectual capacity on their offending behaviour and ability to take part in legal proceedings.
> - Provide advice to individuals before the court, their relatives/carers, service providers or legal representatives about issues related to mental health and relevant legislation.
> - Advise the court whether an assessment in hospital may be required.[89]

The Mental Health Court Liaison Service was established following a commitment in the 2012 State Budget to provide funds for a mental health court diversion and support program.[90]

[89] Department of Justice, personal communication, 10 December 2021.
[90] Stokes B, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities,* 2012, Perth, p. 111.

5.3.6 Western Australian specialist courts provide specific assessments and interventions for people with mental health and/or alcohol and other drug issues

Western Australian specialist courts provide specific assessments and interventions for people with mental health and/or alcohol and other drug issues with the purpose of diverting people 'away from prison' and to 'provide the care and support they require:'[91]

> **The Start Court** is a Magistrates Court based within the Perth Central Law Courts that specialise in working with offenders who have mental health issues. The program combines access to mental health supports and services, and support for AOD issues if required. To be eligible to participate, the individual can only be charged with an offence that does not have a mandatory custodial sentence, they must have a mental health condition, accept that they have committed the offence(s) that led to the court appearance, enter a guilty plea and be eligible for bail.
>
> The Start Court is operated by a dedicated team that includes a Magistrate, mental health clinicians, community support coordinators and dedicated Police Community Corrections personnel and a Legal Aid 'duty lawyer'. The Start Court's community support coordinators have access to a small amount of discretionary funding that can be used to meet housing, peer support, vocational training, and general support for community living.[92]
>
> **LINKS Court** offers mental health assessment and support to young people who appear before the Perth Children's Court. Any young person appearing before the Court who is suspected of having a mental health issue may be referred to LINKS. The outcomes of the assessment help to guide the future management of the young person's court proceedings and care. LINKS work closely with other services and agencies that operate in the Children's Court and is part of the Children's Court Drug Court team.[93]

The Mental Health Court Diversion and Support Program, comprised of the Start Court and LINKS Court, is the result of a partnership between the Mental Health Commission and the Department of Justice. Other agencies contribute to the program, including the Department of Health, WA Police, Legal Aid WA, Outcare Inc (a Non-Government service provider), and Mental Health Law Centre. The Start Court and LINKS Court commenced operation in 2013.[94]

[91] Department of Justice, personal communication, 10 December 2021.
[92] Department of Justice, personal communication, 10 December 2021.
[93] Department of Justice, personal communication, 10 December 2021.
[94] Magistrates Court of Western Australia, *Start Court*, 2021, viewed 14 December 2021 <https://www.magistratescourt.wa.gov.au/S/start_court.aspx>, and Department of Justice, *Annual Report 2018/19*, 2019, Government of Western Australia, Perth, p. 41.

The Intellectual Disability Diversion Program Court is also a specialist court operating in Western Australia, and is a diversion program offered to adults with a cognitive disability, intellectual disability, or Autism Spectrum Disorder who plead guilty.[95] The Intellectual Disability Diversion Program Court was established in 2003:[96]

> **Intellectual Disability Diversion Program Court** seeks to reduce the number of individuals in the adult criminal justice system who may have an intellectual disability, cognitive disability and/or autism spectrum disorder. The court aims to work with the individual while living in the community to reduce their future contact with the criminal justice system. The court can also identify undiagnosed disability or impairment as well as physical and/or mental health issues. Adult Community Corrections play an integral role in the Court process and facilitate neuropsychological assessments and referrals to the National Disability Insurance Agency with whom ACC support clients' applications for the National Disability Insurance Scheme (NDIS).[97]

The Department of Justice also informed the Office of the commencement of the General Court Intervention Program (**GCIP**), a pilot program that commenced operation in 2021, following the conclusion of the Investigation period:

> The **General Court Intervention Program (GCIP)** is a pilot program led by the Department of Justice, in partnership with Connect Wanju, based at Perth Magistrates Court. The program focusses on providing people on bail with needs-based support through case management and priority access to community services. Accused persons can participate in the GCIP from their first appearance in court, if referred and assessed as suitable. Participation in the GCIP is voluntary.
>
> The program is available to all accused persons, regardless of whether a plea has been entered or whether they intend to plead guilty or not.
>
> GCIP Case Managers conduct assessments of individuals to determine their suitability for the program. If deemed suitable, the Case Manager forwards a referral to Connect Wanju identifying the supports required as discussed with the participant. The Case Manager continues to engage with the participant on a regular basis when referred to Connect Wanju to provide additional support.
>
> The GCIP and Connect Wanju team will work closely with participants over 12 weeks to provide access to a range of services and programs relating to four areas of need:
>
> - Physical and/or mental health concerns.
> - Drug and alcohol dependency and misuse issues.
> - Social and economic needs that contribute to the frequency or severity of offending.
> - Homelessness.

[95] Magistrates Court of Western Australia, *Intellectual Disability Diversion Program Court*, 2021, viewed 14 December 2021 <https://www.magistratescourt.wa.gov.au/I/intellectual_disability_diversion_program_court.aspx>.
[96] Western Australia, *Parliamentary Debates*, Legislative Council, 2 November 2012, p. 7814b-7815a (A Xamon).
[97] Department of Justice, personal communication, 10 December 2021.

5.3.7 Five of the 27 women charged with a criminal offence prior to their suicide had a criminal charge finalised within 90 days of their death (19 per cent)

For the 27 women charged with a criminal offence prior to their suicide, the Office undertook further analysis to learn whether patterns and trends emerged in the proximity of their most recent court date to their death by suicide.

Of these 27 women, five had a criminal charge finalised in the 90 days prior to their death (19 per cent).

5.3.8 Five of the 27 women charged with a criminal offence prior to their suicide had a criminal charge outstanding at the time of their death (19 per cent)

The Office undertook further analysis for the 27 women charged with a criminal offence prior to their suicide, to identify any patterns and trends in their outstanding criminal charges.

Of the 27 women, five had a criminal charge outstanding at the time of their death (19 per cent).

5.4 Contact between corrective services and the 68 women and children

5.4.1 Sixteen of the 68 women and children had contact with corrective services

The Department of Justice's corrective services area (**corrective services**) is responsible for Western Australia's adult prison and youth detention populations, as well as those managed in the community by Adult Community Corrections and Youth Justice Services.

Of the 68 women and children, 15 women and 1 child had contact with corrective services.

Eight of the 16 women and children who had contact with corrective services were Aboriginal and/or Torres Strait Islander.

5.4.2 Most of the 16 women and children had contact with custodial and community-based corrective services

In determining the nature of contact between corrective services and the 16 women and children with corrective services contact prior to their death, the Office identified where women and children had contact with Youth Justice Services (when aged under 18 years), Adult Community Corrections and/or custodial facilities, as follows:

- three women and one child had contact with Youth Justice Services and/or a juvenile detention facility during their childhood (25 per cent);
- eleven women had contact with Adult Community Corrections (69 per cent); and
- nine women had contact with an adult custodial facility (56 per cent).

Six of the 11 women managed by Adult Community Corrections were identified in one or more WA Police family and domestic violence incident reports during their during the period of their management in the community.

5.4.3 Five women known to corrective services died while on an active period of adult community management or during a custodial stay

The Office identified that five women known to have experienced family and domestic violence and contact with corrective services prior to their suicide, died while on an active period of adult community management or during a custodial stay (31 per cent of the 16 women and children who had contact with corrective services). Three of the five women were Aboriginal and/or Torres Strait Islander.

5.4.4 The Department of Justice's current practices and reform agenda for the management of suicide and self-harm risk for adults in contact with community-based settings

The Department of Justice's Adult Community Corrections *Information sheet for case managers – Suicide Risk and Self-Harm* identifies that mental health and suicide are prominent issues within prison and the community, noting that:

> People involved in the Justice Services are at a higher risk of engaging in suicide and self-harm. Further, those who struggle with mental health are more likely to engage in self-harm behaviours or suicidal ideation/attempts, with the rate of mental health within the prison up to 5 times higher than the general population. Suicide and self-harm are complex issues that affect individuals, the community, families, staff and fellow inmates, and it is important to recognise the signs when dealing with clients.[98]

The Department of Justice advised the Office that Adult Community Corrections 'contributes to the management of those offenders and defendants who are subject to community supervision in a number of ways as a part of the individuals case management,'[99] noting:

> ACC utilise the Kessler 10 (K 10) Self Harm Assessment Tool and Stress Management Workbooks for those individuals presenting with mental health issues.
>
> The ACC Handbook provides guidance to ACC Case Managers in the management of individuals presenting with mental health and particularly self-harm issues. This guidance incorporates safety screening, assessing mental health and referral pathways.[100]

In addition to this guidance, the Department of Justice further advised the Office that:

- '[all Community Corrections Officers] are required to complete the Correctional Officer Foundation Program,' which includes 'Gatekeeper – Suicide Awareness' training (two-day training), 'Mental Health First Aid' training (two-day training), and 'Mental Health Matters' (half a day training); and
- 'on every occasion that ACC receives confirmation of the death of an offender/defendant subject to ACC supervision, the ACC Directorate will determine if the circumstances of the death require a review of the deceased's Case Management:'

[98] Department of Justice, *Adult Community Corrections Practice Tools: Information sheet for case managers – Suicide Risk and Self-harm v 1*, received by electronic communication, 13 October 2021.
[99] Department of Justice, electronic communication, 10 December 2021.
[100] Department of Justice, electronic communication, 10 December 2021.

> This review is undertaken by an ACC Manager who is not connected with the case and with the purpose of ascertaining if the deceased's Case Management was conducted in accordance with ACC policy and practice, plus to identify if there were any missed opportunities.
>
> The outcome of these reviews are used to identify if there are any systemic Case Management issues and provides the opportunity to implement any necessary remedial action whether it be on a local level or for ACC state-wide.[101]

Recommendation 2: The Department of Justice consider the findings of this Investigation and continues to identify opportunities for community-based suicide prevention for women known to have been victims of family and domestic violence related crime including those:

- receiving support from court counselling and support services; and
- convicted of criminal offences and being managed in the community by Adult Community Corrections.

5.5 Information sharing

5.5.1 FVIRs contain information useful for corrective services in managing family and domestic violence offenders in the community but are not regularly provided to the Department of Justice outside of the East Kimberley Family Violence Response Team partnership

The Department of Justice has identified that 'police FVIRs are extremely useful for managing [family and domestic violence] offenders in the community. FVIRs capture rich contextual information which can help to build a pattern of the perpetrator's behaviour over time, which assist the Department in monitoring escalations in risk.'[102] During this investigation, the Deparmtent of Justice relevanly informed the Office that:

> Chapter 19 of the ACC Handbook also contains protocols on information sharing with WAPF, covering a number of different scenarios. However, there is currently no formal protocol for the regular provision of Family Violence Incident Reports (FVIRs) from WAPF to ACC. In practice, individual FVIRs may be provided to ACC on request, but this is at the discretion of the WAPF district office.
>
> Generally, where a CCO becomes aware of a family violence incident or holds suspicions of violence, they can issue a request to their Senior CCO. The Senior CCO will submit a list of FVIRs to their local WAPF Family Violence Unit. The response time and depth of information provided varies, and some WAPF districts have noted the administrative burden associated with these requests.
>
> One exception to this is in the Kimberley, where ACC does not need to make specific requests WAPF. The East Kimberley Family Violence Response Team is a partnership between WAPF, [Department of] Communities and a local non-government FDV service, which proactively coordinates multi-agency input to adequately assess dynamic FDV risks. Police send daily reports of all FVIRs

[101] Department of Justice, electronic communication, 13 October 2021.
[102] Department of Justice, personal communication, 29 October 2020.

> to ACC (and other relevant agencies) with a standard request for information regarding all the families involved.[103]

As identified, WA Police do not currently provide FVIRs to the Department of Justice on a regular basis outside of the East Kimberley Family Violence Response Team partnership. However, legislative powers for sharing information about the safety of persons subjected to or exposed to family violence have existed within sections 28A to 28C of the *Children and Community Services Act 2004* since 1 January 2016. These provisions:

> … enable the sharing of relevant information between other public authorities (prescribed in the Regulations) and certain agencies in the community services sector in relation to children's wellbeing and the safety of persons subjected or exposed to family violence. Family Court judges, registrars, magistrates and consultants are now prescribed authorities for the purposes of sharing information under section 28B of the Act, in addition to 16 other prescribed authorities, including WA Police [and the Department of Justice].[104]

The Department of Justice further advised the Office that information sharing arrangements for FVIRs will be developed as part of reforms to the Family and Domestic Violence Response Team model. The Department of Justice stated that:

> As part of the Project, the following deliverables will be realised to address the critical risks identified as part of the external review of the Family and Domestic Violence Response Team model:
>
> - Information exchange: An interagency agreement will be established to formalise information sharing arrangements to improve the timely exchange and use of purposeful risk-relevant information.[105]

[103] Department of Justice, personal communication, 29 October 2020. Source utilises the following acronyms: ACC (Adult Community Corrections), WAPF (Western Australia Police Force), CCO (Community Corrections Officer), and FDV (family and domestic violence).
[104] Department of Communities, *Statutory Review of the Children and Community Services Act 2004*, November 2017, Government of Western Australia, p. 62, <https://www.wa.gov.au/system/files/2021-10/Statutory-Review-of-the-Children-and-Community-Services-Act-2004.pdf>.
[105] Department of Justice, Personal Communication, 4 November 2021.

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6 Contact with the Department of Health among the 68 women and children who died by suicide

6.1 Overview

The Office obtained all emergency department attendance and hospital admission records for the 410 people who died by suicide in Western Australia, for the period between 1 January 2012 and their death, from the Department of Health's Emergency Department Data Collection and Hospital Morbidity Data Collection.

Excluding emergency department attendances and hospital admissions relating to death, the Office identified that, of the 410 people who died by suicide, 340 (83 per cent) attended a hospital emergency department or were admitted to hospital prior to their death.

These 340 people had a total of 1,550 inpatient separations and 1,797 emergency department attendances between 1 January 2012 and the date of their death.[106]

In analysing and considering the data about hospital contact that follows, it is important to bear in mind that the data presented only records the instances a woman or child sought treatment for any reason. The Office acknowledges that the data within this Chapter does not reflect whether or not there was a missed opportunity to recognise and respond to the dual risks of family and domestic violence and suicidal behaviour for each person. Further, the data presented does not convey instances of good practice and high-quality support work provided by hard-working health professionals often working in traumatic, highly stressed and high workload environments in order to deliver the best possible medical care to Western Australians, that may be identified in the course of our review of identified information.

[106] Not included in this analysis were:
- thirty-three emergency department attendances with a disposal code indicating that a person died;
- forty hospital admissions with a method of patient discharge code indicating that a person died during an inpatient stay; and
- six-hundred and forty-one emergency department attendances which had no recorded diagnosis or symptom code.

Table 18: Emergency department attendances and hospital admissions, by admission type, Aboriginal and/or Torres Strait Islander status and age group, for the 68 women and children

	Total (n=68)		ATSI (n=12)		Under 26 (n=20)		26 years and over (n=48)	
Attended an emergency department (ED)	59	87%	10	83%	11	55%	47	98%
Mental health condition related ED attendance	35	51%	5	42%	6	30%	31	65%
Self-harm related ED attendance	24	35%	3	25%	5	25%	18	38%
Family and domestic violence	2	3%	-	-	-	-	-	-
Suicidal ideation related ED attendance	20	29%	3	25%	3	15%	17	35%
Admitted to hospital	55	81%	11	92%	15	75%	42	88%
Mental health	33	49%	6	50%	7	35%	26	54%
Intentional self-harm	24	35%	3	25%	6	30%	18	38%
Family and domestic violence	7	10%	5	42%	3	15%	4	8%
Suicidal ideation	3	4%	1	8%	1	5%	2	4%

Source: Ombudsman Western Australia

6.2 Hospital admissions for the 68 women and children

6.2.1 Of the 68 women and children, 55 were admitted to hospital on 281 occasions between 1 January 2012 and the date of their death in 2017 (81 per cent)

Excluding admissions where a person died by suicide, the Office identified that 55 of the 68 women and children (81 per cent) had one or more hospital admissions between 1 January 2012 and the date of their death (Table 18). Further, the Office identified that 49 of the 55 women and children admitted to hospital were admitted on multiple occasions (89 per cent), with only seven admitted once (13 per cent).

Eleven of the twelve Aboriginal and/or Torres Strait Islander women and children were also admitted to hospital (92 per cent). Ten of these 11 Aboriginal and/or Torres Strait Islander women and children were admitted to hospital on more than one occasion (91 per cent), and only one was admitted on a single occasion (nine per cent).

6.2.2 Thirty-three of the 55 women and children who had been admitted to hospital, had been admitted on one or more occasions for mental health issues (60 per cent)

Mental illness is considered a major risk factor for suicide, with the World Health Organisation identifying that the 'link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established in high-income countries.'[107]

[107] World Health Organisation, *Suicide*, 17 June 2021, viewed 22 December 2021, <https://www.who.int/news-room/fact-sheets/detail/suicide>.

In this context, the Office also notes that Western Australia's Suicide Prevention Framework highlights the following 'myth':

> MYTH: "Everyone who engages in suicidal behaviour has a mental illness."
>
> Thoughts of suicide can happen to anyone, including those who have no history of mental health conditions. People living with mental health conditions, however, are at increased risk of suicide.[108]

This was also highlighted recently in a hearing to Australia's Royal Commission into Defence and Veteran Suicide:

> Dr Turner [Executive Director of Metro north Mental Health, Queensland], a psychiatrist, said she and her colleagues recognised the system was failing the large number of people who suicided because it was based on the assumption people with suicide were suffering a mental illness.
>
> "Through my whole career, the focus had been on risk assessment ... and yet we knew we were seeing people who were dying by suicide that did not fit into that group," Dr Turner said.
>
> "Our job was identifying people with mental illness ... but what we found among those people dying by suicide, only a very small number would be in that group."
>
> … Several international studies were currently analysing patient health records to establish what red flags to look out for, dating back as far as 15 years.[109]

Accordingly, the Office undertook further analysis of the diagnoses recorded for each hospital admission, as shown in Table 19.

Table 19: Hospital admissions for the 55 women and children, by type of admission, number of admissions and cumulative length of stay in days, from 1 January 2012 until their death in 2017

	Intentional self-harm	Mental health	Suicidal ideation	Family and domestic violence (when recorded as an external cause or additional diagnosis)
Number of women and children admitted to hospital (n=55)	24 (44%)	33 (60%)	3 (5%)	7 (13%)
Number of hospital admissions (n=343)	50 (15%)	122 (36%)	6 (2%)	8 (2%)
Cumulative length of stay in days (n=1,478)	247 (17%)	1,019 (69%)	94 (6%)	20 (1%)

Source: Ombudsman Western Australia

[108] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, Government of Western Australia, Perth, p. 24.
[109] Cornwall D, 'Psychological tests miss suicide risk,' *Canberra Times*, Canberra, 8 December 2021, viewed 22 December 2021 <https://www.canberratimes.com.au/story/7542465/psychological-tests-miss-suicide-risk/?cs=14264>.

6.2.3 Victims of family and domestic violence with and without a FVIR history, were admitted at a similar average frequency

Of the 68 women and children who died by suicide, 55 were admitted to hospital for any cause during the five years prior to their death, on a total of 344 occasions.

Of the 55 women and children admitted to hospital, 42 had also had family and domestic violence recorded with the WA Police in a FVIR (76 per cent). These 42 women and children with a history of WA Police contact for family and domestic violence were admitted to hospital on 221 occasions (an average of five admissions from 1 January 2012 until the date of their death in 2017, per person).

Of the 55 women and children admitted to hospital, 25 had no recorded history of contact with the WA Police in the form of a FVIR (45 per cent). These 25 women and children without any history of contact with the WA Police for family and domestic violence were admitted to hospital on 122 occasions (an average of five admissions from 1 January 2012 until the date of their death in 2017, per person).

6.2.4 Twenty-four of the 55 women and children who had been admitted to hospital, had been admitted on one or more occasions for intentional self-harm (44 per cent)

Arising from the analysis shown in Table 19, the Office also identified that of the 55 women and children admitted to hospital, 24 had been admitted on one or more occasions for intentional self-harm (44 per cent).

The Office's analysis also identified that only 3 of the 55 women and children admitted to hospital had a recorded diagnosis of suicidal ideation. Seven women and children had diagnoses indicative of family and domestic violence (that is, the ICD-10-AM external cause codes indicating an assault perpetrated by a spouse or family member and the additional diagnosis Z63 codes for relationship problems impacting health status).

6.3 Emergency department attendances for the 68 women and children

6.3.1 Of the 68 women and children known to have experienced family and domestic violence prior to their suicide, 59 attended an emergency department on 506 occasions from 1 January 2012 until the date of their death in 2017 (87 per cent)

Excluding attendance where a person died by suicide, the Office identified that 59 of the 68 women and children known to have experienced family and domestic violence prior to their suicide (87 per cent) attended an emergency department on one or more occasions between 1 January 2012 and the date of their death.

Further, the Office identified that most of the 59 women and children who attended an emergency department presented on multiple occasions, with only nine presenting at an emergency department on a single occasion (15 per cent).

Ten of the 11 Aboriginal and/or Torres Strait Islander women and children known to have experienced family and domestic violence prior to their suicide, also attended an emergency department (91 per cent). Nine of these 11 Aboriginal and/or Torres Strait Islander women and children attended an emergency department on more than one occasion, and only one was attended an emergency department on a single occasion (10 per cent).

6.3.2 Of the 59 women and children that attended an emergency department, 35 attended on one or more occasions for mental health related reasons (59 per cent)

In a manner similar to the analysis conducted for hospital admissions, the Office undertook further analysis of the diagnoses and symptoms recorded for each emergency department attendance, as shown in Table 20. This analysis identified that among the 59 women and children who attended an emergency department, 35 women and children attended an emergency department for mental health reasons (59 per cent) on 114 occasions. Twenty-three women and children had multiple recorded emergency department attendances for mental health reasons (40 per cent).

Table 20: Emergency department attendances for the 59 women and children, by type of admission and number of admissions, from 1 January 2012 until their death in 2017

	Intentional self-harm	Mental health	Suicidal ideation	Family and domestic violence (when recorded as an external cause or additional diagnosis)
Number of women and children that presented to an emergency department (n=59)	24 (41%)	35 (59%)	20 (34%)	2 (3%)
Number of emergency department attendances (n=506)	42 (8%)	114 (26%)	43 (8%)	2 (0.4%)

Source: Ombudsman Western Australia

6.3.3 Twenty-four of the 59 women and children known to have experienced family and domestic violence prior to their death attended an emergency department for intentional self-harm (41 per cent)

Arising from the analysis shown in Table 20, the Office also identified that 24 of the 59 women and children that attended an emergency department, attended on one or more occasions for intentional self-harm (41 per cent).

6.4 Proximity of contact with hospitals for the 59 women and children who attended an emergency department and/or were admitted to hospital between 1 January 2012 and their death

6.4.1 Thirty-four of the 59 women and children who attended an emergency department between 1 January 2012 and their death in 2017, presented at an emergency department within the 90 days prior to their death

The Office analysed the time between the last attendance at an emergency department and death for each of the 59 women and children who presented at an emergency department between 1 January 2012 and their death in 2017. Of these 59 women and children, 34 had attended an emergency department within the 90 days prior to their death (58 per cent), as shown in Table 21.

Sixty-five per cent of these women and children who attended an emergency department in the 90 days prior to their suicide had also previously had contact with the WA Police regarding their experiences of family and domestic violence.

Table 21: Time between last emergency department attendance and death, for the 59 women and children

Time between last emergency department attendance and suicide	Number of women and children (n = 59)	Percentage
7 days or less	8	14%
one week to 30 days	10	17%
31 to 90 days	14	24%
91 and 365 days	20	34%
366-730 days	2	3%
Greater than 2 years	5	9%

Source: Ombudsman Western Australia

6.4.2 Twenty of the 55 women and children admitted to hospital between 1 January 2012 and their death in 2017, were discharged from a hospital admission within the 90 days prior to their death

The Office also analysed the time between the last attendance at a hospital and death for each of the 55 women and children admitted to hospital between 1 January 2012 and their death in 2017.

Of these 55 women and children, 20 had been discharged from an admitted hospital stay within the 90 days prior to their death (58 per cent), as shown in Table 22.

Table 22: Time between last in-patient hospital stay discharge date and death, for the 55 women and children admitted to hospital between 1 January 2012 and their death in 2017

Time between last separation from an admitted hospital stay	Number of women and children (n = 55)	Percentage
7 days or less	6	12%
one week to 30 days	3	5%
31 to 90 days	11	21%
91 to 365 days	10	17%
366 to 730 days	14	26%
Greater than 2 years	11	19%

Source: Ombudsman Western Australia

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7 The 20 children and young victims of family and domestic violence who died by suicide

7.1 Background

7.1.1 *Preventing suicide by children and young people 2020* identified that 76 per cent of Western Australian children who died by suicide between 1 July 2009 and 30 June 2018 had allegedly experienced family and domestic violence

In 2020, the Ombudsman tabled his major own motion investigation report on *Preventing suicide by children and young people 2020*, which analysed the deaths of 115 children and young people under the age of 18 who died by suicide in Western Australia between 1 July 2009 and 30 June 2018.

This investigation included an extensive literature and practice review, significant consultation with government and non-government agencies and experts and comprehensive collection and analysis of the records and data from the Office and government and non-government agencies. The Office also analysed the characteristics of the 115 children and young people, including the following factors associated with suicide summarised in Figure 6.

Figure 6: Factors associated with suicide considered by the Office in *Preventing suicide by children and young people 2020*

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 identified four groups of children and young people based on patterns in the factors associated with suicide and contact with State government departments and authorities, and identified relevant suicide prevention activities for each group, as summarised in Figure 7.

Figure 7: Groups identified of children and young people who died by suicide identified by the Office

Group 1	Group 2	Group 3	Group 4
Characteristics			
70 children and young people: • all allegedly experienced one or more forms of child abuse or neglect; and • most also experienced mental health issues and suicidal ideation and behaviour.	17 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	18 children and 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.	10 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			
Most of the children and young people in Group 1 were known to the: • (then) Department for Child Protection and Family Support; and • Department of Health. These children and 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 children and 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.	Most 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

Arising from this analysis, the Office identified that the majority of the 115 children and young people (70 children and young people, 61 per cent) experienced significant and enduring life difficulties, including alleged child abuse or neglect and family dysfunction. Significantly, among these 70 children and young people (referred to in the report as 'Group 1') 53 had allegedly experienced family and domestic violence prior to their death (76 per cent).

The report also noted that the 70 children and young people in Group 1 who died by suicide, were frequently in contact with State government departments and authorities prior to their death, often as a result of a number of significant adversities:

> The majority of these children and young people also experienced multiple other factors associated with suicide (64 children and young people, 91 per cent) including suicidal ideation (48 children and young people, 69 per cent), mental health issues (43 children and young people, 61 per cent), substance use (45 children and young people, 64 per cent) and adverse family experiences (53 children and young people, 76 per cent).
>
> Group 1 are frequently in contact with State government departments and authorities. Sixty-nine children and young people in Group 1 were the subject of child protection notifications to the Department of Communities (99 per cent). Most of the children and young people attended a public school at some time in their life (67 children and young people, 96 per cent), and 45 per cent (32 children and young people) had been referred to public child and adolescent mental health services during their lives.[110]

The Office's analysis of the contact between child protection services and the children and young people in Group 1 who died by suicide identified several key patterns and trends:

- concerns about the wellbeing of each child and young person were raised, on average, 14 times with the Department of Communities (ranging from 0 to 70);
- concerns about the wellbeing of the children and young people in Group 1 were not always viewed as a 'child protection concern', with allegations of neglect and emotional abuse arising from experiences of family and domestic violence frequently recorded as a 'family support' issue;
- only 12 per cent of interactions with the Department of Communities progressed to a Child Safety Investigation (formerly known as a Safety and Wellbeing Assessment), with the Department taking 'no further action' in relation to the majority of contacts relating to these children and young people (56 per cent);
- concerns that the parents/caregivers of a suicidal child or young person were unable or willing to provide adequate care for the child or young person were not consistently assessed in accordance with relevant Casework Practice Manual guidance;
- the highest volume of contact between the children and young people in Group 1 and the Department of Communities occurred between the ages of 12 and 14; and

[110] Ombudsman Western Australia, *Preventing suicide by children and young people 2020, Volume 1: Ombudsman's Foreword and Executive Summary*, September 2020, p. 25.

- 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 with an increased risk of suicide.[111]

The Office noted that the impact of the Department of Communities' recently introduced Centralised Intake Model was unable to be assessed using the data obtained during the investigation, and that this new model aimed to achieve greater consistency in the Department's identification of cumulative harm.

In this context, the Ombudsman recommended that the Department of Communities continue to monitor its performance with regard to children and young people in frequent contact with the Department, who may be at risk of self-harm or suicide:

> **[*Preventing suicide by children and young people 2020]* 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.[112]

Information provided by the Department of Communities and other agencies for that report identified that there was no program for collaborative case management of children and young people with complex needs who were at risk of suicide or self-harming behaviours, and who were not in the care of the Chief Executive Office of the Department of Communities.

[111] Ombudsman Western Australia, *Preventing suicide by children and young people 2020 Volume 1: Ombudsman's Foreword and Executive Summary,* 2020, p. 75-77*;* Ombudsman Western Australia, *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,* 2020, p. 235.
[112] Ombudsman Western Australia, *Preventing suicide by children and young people 2020 Volume 1: Ombudsman's Foreword and Executive Summary,* 2020, p. 78.

The Office highlighted barriers to information sharing and research literature identifying that children and young people who have multiple risk factors and a long history of involvement with multiple agencies (like the 70 children and young people in Group 1):

- were often viewed as being 'hard to help', 'resilient' or making choices to put themselves at risk, rather than as exhibiting unsafe coping mechanisms or behaviour;[113] and
- were often not provided with effective service responses due to challenges faced by agencies in recognising neglect in older children; and
- frequently displayed challenging behaviours including those relating to child sexual exploitation, criminal exploitation, gang-related activity or violence, and running away from home that was rarely understood from a cumulative harm or trauma informed perspective.[114]

The Ombudsman recommended that the Department of Communities and other relevant agencies work together and enhance their suicide prevention efforts by providing a targeted intervention for at risk children and young people known to be experiencing multiple risk factors associated with suicide:

> **[*Preventing suicide by children and young people 2020]* 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.[115]

7.1.2 A report on the steps taken to give effect to the recommendations arising from *Preventing suicide by children and young people 2020*

The Department of Communities' report to the Ombudsman regarding the steps taken to give effect to Recommendations 6 and 7 of *Preventing suicide by children and young people 2020* stated that:

> In 2019, the Department of Communities (Communities) undertook a thematic analysis of 22 finalised child death reviews finalised since 1 July to:
>
> - collate information about vulnerable cohorts within the community including common risk factors;
> - identify common practice issues related to Communities administration of the *Children and Community Services Act 2004* and related policies and procedures;
> - identify systemic barriers to child safety; and
> - draw connections between the findings of child death reviews and other oversight agency investigations.

[113] 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*, 2008, United Kingdom Department for Children, Schools and Families, London, p. 12.
[114] 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*, 2008, United Kingdom Department for Children, Schools and Families, London, p. 12.
[115] Ombudsman Western Australia, *Preventing suicide by children and young people 2020 Volume 1: Ombudsman's Foreword and Executive Summary,* 2020, p. 82.

> Young people age 10 to 18 years were identified through the thematic analysis as an emerging at risk cohort.
>
> Following from the thematic analysis, Communities has undertaken a further cohort review of at-risk youth. The following themes emerged from the review:
>
> 1. Improving practice guidance about the Department's role and responsibilities in circumstances where a child or young person is referred to the Department in relation to concerns about their wellbeing. This includes recognising wellbeing concerns as indicators of abuse and neglect, assessing harm arising from cumulative abuse and understanding when observed strengths, resilience or other protective factors may translate into safety in relation to the identified abuse/danger.
>
> 2. Improving interagency communication and collaboration to better respond to complex intersecting issues in families where there is a young person at risk of suicide or other type of harm including as a result of substance abuse; and
>
> 3. Addressing practice and systemic issues through dedicated strategic policy and frameworks such as the At-Risk Youth Strategy.
>
> Common risk factors across both reviews included exposure to family violence and parental substance use. Other risk factors for this cohort included parental mental illness, parents who experienced abuse as children, homelessness or housing instability and Aboriginality. The identification of these risk factors will assist Communities to target implementation strategies in the development of the internal implementation plan for improving responses for at-risk youth.
>
> Communities is undertaking a scoping of work required to establish an internal implementation plan for improvements to practice and operations in relation to at-risk youth. Findings from the Ombudsman Own Motion Investigation will also be used to inform the strategies for the implementation of the four recommendations delivered to Communities. Further detail of the work to implement the necessary improvements will be provided to your office in October 2021.[116]

The Ombudsman concluded that 'steps have been taken and are proposed to be taken to given effect to' both Recommendation 6 and Recommendation 7 and stated that:

> Further, the Office will carefully consider the report from the Department of Communities as set out in the recommendation upon receipt and publish an update on the steps taken to give effect to Recommendation 6 in the Ombudsman's 2021-22 Annual Report.[117]

[116] Ombudsman Western Australia, *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020*, 2021, p. 41-51.
[117] Ombudsman Western Australia, *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020*, 2021, p. 45 and 51.

7.1.3 Developments since *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020*

On 22 October 2021, the Director General of the Department of Communities provided the Office with a 'Progress update' on Recommendation 6 of *Preventing suicide by children and young people 2020*, which stated that:

> Communities has recently established the Reviews and Recommendations Oversight Group (the Oversight Group), to align and streamline activity across the agency. The Oversight Group is scoped to endorse themed work packages and oversight the implementation of internal and external recommendations delivered to Communities.
>
> Oversight Group members, who represent relevant divisions across Communities and hold decision-making authority, are responsible for developing an environment of continuous service improvement through the identification of:
>
> - opportunities to inform and drive reforms through regular review of risk themes and practice trends; and
> - interdependencies and opportunities to work across business areas to deliver holistic, effective results.
>
> The Oversight Group is overseeing the implementation of [Recommendation] … 6 from the Ombudsman's Own Motion Investigation, *Preventing suicide by children and young people 2020* …
>
> In September 2021, the Oversight Group endorsed the project scope which will address Recommendation 6. The Cumulative Harm Project will improve policy frameworks, practice guidance, service delivery to support sustainable, holistic responses for children and young people who:
>
> - experience cumulative harm through multiple repeat presentations, which considered in isolation, do not reach the intake threshold.
> - experience acute distress as a result of cumulative harm and are at risk of suicide and/or suicide behaviours (including suicide attempt, suicidal ideation, self-harm and reckless risk-taking).
>
> The Cumulative Harm Project proposes to achieve these objectives by:
> - Reviewing and assessing policies, practice guidance, processes and tools that are used to address identifying, responding and intervening in:
>   - children, young people and families with history with Communities who are the subject of multiple interactions and are at risk of, or currently experiencing, cumulative harm; and
>   - children and young people with history with Communities who are at risk of harm as a result of suicide behaviours, including those of a parent, carer or guardian.
>   - Develop improvement opportunities for service delivery, including communications, training, and development for frontline staff.
>
> The Cumulative Harm Project will include data collection and research to assess and develop findings, which will be tested with key stakeholders. From this, recommendations relating to practice guidance, staff engagement opportunities and a corresponding implementation plan will be developed. It is anticipated that this Project will be finalised by June 2022.

Communities has updated the *Casework Practice Manual* (CPM) which provides guidance for Child Protection Workers, as authorised officers of the CEO, in carrying out the functions and powers of *Children and Community Services Act 2004* (the Act). On 30 August 2021, the CPM entry '*Alcohol and other drug use - at risk young people'* was introduced. This entry includes guidance on responding to young people, both in the CEO's care and otherwise, who are assessed as at immediate high risk due to their alcohol or other drug use, inclusive of medical and/or mental health crisis.

As you might be aware the Children and Community Services Amendment Bill 2021 passed in WA Parliament on 14 October 2021. Amendments were made regarding young people once they leave the care of the CEO's care. These changes included:

- a leaving care plan must be prepared once a child reaches 15 years of age;
- leaving care plans should include the social services proposed to be provided for the child post-care;
- children leaving care must be provided with social services the CEO considers appropriate having regard to the child's needs, regardless of whether those needs are identified in the child's last care plan;
- children leaving care are to receive written information on their entitlements post-care;
- Public authorities named in regulations must prioritise CEO requests for assistance to a child in care, a child under an SGO or a care leaver who qualifies for assistance until they reach 25, provided it would be consistent with and not unduly prejudice the performance of the public authority's functions to do so.

As you might be aware Communities, in partnership with Anglicare WA, have piloted Home Stretch WA. The State Government in its 2021-22 State Budget committed $37.2 million to expand the Home Stretch pilot into a permanent state-wide program to enhances access to supports and services for young people aged 18 to 21 years who are leaving, or have left, out-of-home care.

7.1.4 Suicide continues to be a leading cause of death for Western Australian children and young adults

National statstistics published since *Preventing suicide by children and young people 2020* have highlighted the continuing tragedy of suicide among children and young adults, with the Australian Bureau of Statistics reporting in 2020 that suicide 'remained the leading cause of death of children [aged between 5 and 17 years of age] in Australia' and that 'over one-third of deaths in 15-24 year olds are due to suicide'.[118]

[118] Australian Bureau of Statistics, C*auses of Death, Australia 2020,* 2021, viewed 10 August 2022, <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2020>.

The State government's *Beyond 2020: WA Youth Action Plan 2020-22* identified that young people aged 10 to 25 years make up 19.9 per cent of Western Australia's population and reported that:

> Young people told us that they are worried about getting support not only for their own mental health but also how to help their friends who are struggling with increased social isolation, poor employment prospects and finding a safe place to live. …
>
> Those living in regional areas feel forgotten and without as many opportunities as those living in the city. Young people said they feel voiceless, patronised by older people and excluded from decisions that affect them.[119]

Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020–2030 seeks to 'reduce family and domestic violence in Western Australia' to achieve its vision of a 'Western Australia where all people live free from family and domestic violence'. *Path to Safety* has nine guiding principles, including that:

- 'Children and young people exposed to family and domestic violence are victims'; and
- 'The safety and wellbeing of victims is the first priority'.[120]

7.1.5 Recent State government strategies and reports recognise that children who die by suicide frequently experience family and domestic violence and are referred to child protection services

Path to Safety identifies the 'high prevalence of family and domestic violence in child protection cases' including a 'recent Department of Communities analysis of 600 children entering care .. [which found] that family and domestic violence was a significant issue contributing to or causing harm' in 88 per cent of cases.[121]

Significantly, *Path to Safety* also noted that 'at risk' children and young people displaying 'antisocial or negative behaviours' during their contact with State education, health, police and child protection services, may have been experienced family and domestic violence but are not recognised as victims due to challenges in:

> … identify[ing] 'at risk' young people who have been exposed to family and domestic violence and to recognise the link between trauma, learnt behaviours and their current life trajectory. Some young people's antisocial or negative behaviours, attitudes and actions may serve as early warning signs.[122]

[119] Government of Western Australia, *Beyond 2020: WA Youth Action Plan 2020-22*, 2021, Department of Communities, p. 6-7.
[120] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020–2030*, 2021, Government of Western Australia, p. 6.
[121] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020–2030*, 23 April 2021, Government of Western Australia, p. 37.
[122] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020–2030*, 23 April 2021, Government of Western Australia, p. 37.

Path to Safety also highlights 'the need to improve protective responses to children and young people … [and] the capacity of the family and domestic violence system to support children and young people, as well as the capacity of the child protection system to appropriately respond to family and domestic violence.'[123]

The State government's draft *Aboriginal Family Safety Strategy 2022 – 2032 Western Australia's Strategy to Reduce Family Violence Against Aboriginal Women and Children* identified that 'family violence [is] … a factor in the lives of young people who suicide [and] a contributing factor to placing families and children at high risk of contact with child protection and juvenile justice systems.'[124]

Similarly, the *Final Report of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in Western Australia* observed that between '2009 and 2018, 60 per cent of children who died by suicide had been subject to a child protection report.'[125]

7.1.6 The research literature identifies a gap in evidence on the impact of childhood contact with child protection services on subsequent mortality and suicide of young adults

The research literature estimates that up to 20 per cent of Australian children experience child abuse and/or neglect.[126] Research also suggests that one in four children and young adults aged between 10 to 20 years have experienced at least one occasion of family and domestic violence perpetrated against their mother or carer.[127]

The research literature identifies that, despite the well-documented and profound adverse physiological, social and economic effects of child abuse and neglect on children's physical health, mental health, and development, 'the effect on mortality has receive limited attention, especially in adolescence and young adulthood.'[128]

[123] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020–2030*, 23 April 2021, Government of Western Australia, p. 37.
[124] Tjallara Consulting Pty Ltd, *Aboriginal Family Safety Strategy 2022 – 2032 Western Australia's Strategy to Reduce Family Violence Against Aboriginal Women and Children: Consultation Draft*, March 2022, Government of Western Australia, p. 11.
[125] Government of Western Australia, *Final Report of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in Western Australia*, 2022, Mental Health Commission, p. 13.
[126] Segal L, Nguyen H, Mansor MM, et al, 'Lifetime risk of child protection system involvement in South Australia for Aboriginal and non-Aboriginal children, 1986-2017 using linked administrative data', *Journal of Child Abuse and Neglect*, 2019 vol. 97, 104145, doi: 10.1016/j.chiabu.2019.104145; Australian Bureau of Statistics. *Personal Safety, Australia*, *2016*, 2017, ABS; Segal L, Armfield JM, Gnanamanickam ES et al, 'Child Maltreatment and Mortality in Young Adults,' *Pediatrics*, 2021, 147(1), e2020023416, viewed 10 August 2022, <https://doi.org/10.1542/peds.2020-023416>.
[127] Indermaur D, *Young Australians and domestic violence: Trends & issues in crime and criminal justice no. 195*, 2001, Australian Institute of Criminology, Canberra, viewed 10 August 2022, <https://www.aic.gov.au/publications/tandi/tandi195>.
[128] Segal L, Armfield JM, Gnanamanickam ES et al, 'Child Maltreatment and Mortality in Young Adults,' *Pediatrics*, 2021, 147(1), e2020023416, viewed 10 August 2022, <https://doi.org/10.1542/peds.2020-023416>.

A recent South Australian retrospective cohort study of all persons born in that State between 1986 and 2003 was the first to use linked administrative data to estimate the impact of childhood abuse and neglect on death rates for people aged between 16 and 33 years, finding that:

> The cohort included 331 254 persons, 20% with CPS contact. Persons with a child protection matter notification and nonsubstantiated or substantiated investigation had more than twice the death rate compared with persons with no CPS contact … The largest differential cause-specific mortality (any contact versus no CPS contact) was death from poisonings, alcohol, and/or other substances …and from suicide.[129]

The authors highlighted the importance of incorporating childhood abuse and neglect into suicide prevention frameworks and the urgent need for policy and service responses to better support at-risk children and families 'across clinical services, child protection and the wider human services sector' as follows:

> This study highlights the importance of incorporating CM [childhood maltreatment] into suicide prevention policy frameworks. It adds weight to the evidence base that CM is toxic to developing brains and to the creation of an intact sense of self, with consequences for suicide risk. A consistently heightened stress response impacts on allostatic load and metabolic health. These pathways have implications for mental health and physical health across the life course.
>
> The excess risk of suicide and substance-related deaths are considerable, and death as an outcome is incontrovertible and potentially avoidable. A commensurate response, involving greater support for at-risk children and families, is urgently required across clinical services, child protection, and the wider human services sector. Suicide intervention strategies must begin early in life. For pediatricians, primary care physicians, psychiatrists, and other clinicians working with children and adolescents, the need to be alert to the maltreating family context when seeing emotional and behavioral problems is reinforced. …
>
> The imperative to keep children safe must extend beyond childhood. Most children exposed to CM who come to the attention of child protection agencies are not placed in OOHC [out of home care], but the outcomes of children who are placed in care, as well as those who are not, suggests not enough is being done to ameliorate harms or prevent further maltreatment. Children with suspicion of CM are at serious increased risk of death as youth and/or young adults. And yet the balance of child protection funding is often focused on OOHC.

[129] Segal L, Armfield JM, Gnanamanickam ES et al, 'Child Maltreatment and Mortality in Young Adults,' *Pediatrics*, 2021, 147(1), e2020023416, viewed 10 August 2022, <https://doi.org/10.1542/peds.2020-023416>.

> Changes to the service response, including the more effective engagement with and upskilling of clinicians in a coordinated, cross-sectoral response to childhood trauma, is desirable. For pediatricians, who are increasingly seeing children with behavioral and development problems, this also means being alert to the possibility of toxic stress driving observed challenging behaviors, and recognizing the potential serious consequences if relational trauma is not addressed and the unique preventive opportunity. As a society, we simply must do better to protect children not just against current harms but also to the extreme consequences of CM across the life course.[130]

From the research literature, the Office identified a gap in available data relating to the contact between child protection services and young adults aged 18 to 25 who die by suicide in Western Australia, including in the context of experiences of family and domestic violence. For this reason and recognising that family and domestic violence is a crime against women, the Ombudsman decided to undertake additional analysis of the contact between child protection services and the 20 children and young women aged 25 and under who experienced family and domestic violence and died by suicide within the cohort of 68 women and children considered as part of this investigation. These children and young women are referred to as the **20 children and young women.**

7.2 Characteristics of the 20 children and young women

The Office used information obtained from WA Police, the Department of Justice, the Department of Health, the Department of Communities and the State Coroner to identify the demographic characteristics of the 20 children and young women.

Table 23 summarises the demographic characteristics of the 20 children and young women.

[130] Segal L, Armfield JM, Gnanamanickam ES et al, 'Child Maltreatment and Mortality in Young Adults,' *Pediatrics*, 2021, 147(1), e2020023416, viewed 10 August 2022, <https://doi.org/10.1542/peds.2020-023416>.

Table 23: Characteristics of the 20 children and young women

Demographic characteristics	Children (10-17) n=9	Young women (18-25) n=11	Children and young women (10-25) n=20
Age			
10 to 14 years	2	0	2
15 to 19 years	7	1	8
20 to 24 years	0	5	5
25 years	0	5	5
Gender			
Female	3	11	14
Male	6	0	6
Aboriginality			
Aboriginal and/or Torres Strait Islander	3	2	5
Non-ATSI	6	9	15
Remoteness of Residence			
Inner Regional	1	1	2
Major Cities	6	9	15
Outer Regional	0	0	0
Remote	1	0	1
Very Remote	1	1	2
SEIFA-IRSD decile rank (within WA)			
1	3	1	5
2	2	1	1
3	0	0	2
4	1	0	1
5	0	1	1
6	1	1	2
7	0	0	0
8	0	1	1
9	2	1	4
10	0	1	1
No Fixed Permanent Address	0	2	2

Source: Ombudsman Western Australia

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8 Contact between the Department of Communities and the 13 children and young women known to the Department

8.1 Background

8.1.1 The Department of Communities' role in supporting the safety and wellbeing of children and families experiencing family and domestic violence

The Department of Communities has a 'legislative mandate' under the *Children and Community Services Act 2004* to:

> … promote the wellbeing of children, individuals and communities, and to provide for the protection and care of children in circumstances where their parents have not provided, or are unlikely or unable to provide, that protection and care.[131]

The Department of Communities' *Emotional Abuse – Family and Domestic Violence Policy* also identifies that the Department 'is responsible for identifying and responding to cases where a child has suffered significant harm or is likely to suffer significant harm because of exposure to family and domestic violence.'[132]

In 2016, a consultation paper released for a statutory review of the *Children and Community Services Act 2004* highlighted that family and domestic violence is 'an ongoing challenge for … child protection agencies', particularly in circumstances where:

> … the strengths and protective capacity of the adult victim (usually the child's mother) are … not enough for mitigating the risk posed by perpetrators of family and domestic violence. Managing the risk to children that is posed by perpetrators of violence requires coordinated safety planning involving extended family, members of the community and other professionals including the civil and criminal justice systems.
>
> In some cases, however, even with extensive safety planning, the perpetrator's use of violence is unable to be stopped, changed or contained. In these circumstances, a child may be critically injured or removed from a protective parent (whether or not they are separated from or residing with the person using violence), due to an inability of the service system, including the police, courts, the Department and community sector services, to create adequate protections for the child and adult victim and reduce or manage the risk posed by the person using violence. …
>
> This is an issue that speaks to the overall capacity of the Western Australian service system to stop, change or contain the violent and abusive tactics used by perpetrators of family and domestic violence, and is not an issue unique to child protection. What is unique to child protection is the dilemma facing child protection workers when deciding whether or not to remove a child from an

[131] Department of Communities, *Emotional Abuse – Family and Domestic Violence Policy*, June 2021, p. 7, viewed 10 August 2022, <https://www.wa.gov.au/system/files/2021-11/Emotional-Abuse-Family-and-Domestic-Violence-Policy.pdf>.
[132] Department of Communities, *Emotional Abuse – Family and Domestic Violence Policy*, June 2021, p. 6, viewed 10 August 2022, <https://www.wa.gov.au/system/files/2021-11/Emotional-Abuse-Family-and-Domestic-Violence-Policy.pdf>.

> otherwise protective parent, thereby risking further trauma to the child and re-victimizing the parent victim.[133]

The Department of Communities' C*asework Practice Manual* highlights that family and domestic violence 'is a factor in the majority of child protection cases.'[134] Further, family and domestic violence can be 'the primary reason for referral' or 'a factor contributing to or causing the presenting problem, such as homelessness or neglect.'[135] Similarly, a 2017 internal review of 433 children in care of the Department of Communities' Chief Executive Officer found that 'at least one episode of family violence had been reported to the Department' in 78 per cent of those cases and 'in 50 per cent there had been five or more episodes reported'.[136]

8.1.2 Referrals to the Department of Communities

As identified in *Preventing suicide by children and young people 2020*, there are three key elements to the Department of Communities' assessment and investigation processes:

- interactions;
- initial inquiries; and
- child safety investigations (formerly known as 'SWA's or 'safety and wellbeing assessments').

8.1.2.1 Interactions

Any member of the community in Western Australia may make a referral or notification of concern for a child's safety and wellbeing to the Department of Communities, including staff of State government departments and authorities and:

> … occupational groups which are mandatory reporters of child sexual abuse, family and community members, health and medical professionals, education providers, police, and service providers in the community services sector.[137]

This initial contact with the Department of Communities, and the Department's assessment and decision making in response to the information received, is recorded in the Department's ASSIST client management system as an **interaction**.[138]

In 2017, the Department of Communities' *Casework Practice Manual* relevantly stated that during an interaction, officers 'assess the information they have received and ascertain, what, if any, further information and assessment is needed' through 'clarifying information

[133] Department for Child Protection and Family Support, *Review of the Children and Community Services Act 2004: Consultation Paper*, 2017, Government of Western Australia, p. 23-24, <https://www.wa.gov.au/system/files/2021-10/Review-CCSA-Consultation-Paper.pdf>.
[134] Department of Communities, *Casework Practice Manual: 2.3.1 Assessing emotional abuse – family and domestic violence*, viewed 5 August 2022 < https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=153>.
[135] Department of Communities, *Casework Practice Manual: 2.3.1 Assessing emotional abuse – family and domestic violence*, viewed 5 August 2022 < https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=153>.
[136] Department of Communities, *Statutory Review of the Children and Community Services Act 2004*, November 2017, Government of Western Australia, p. 60, <https://www.wa.gov.au/system/files/2021-10/Statutory-Review-of-the-Children-and-Community-Services-Act-2004.pdf>.
[137] Department of Communities, *Policy on assessment and investigation processes for child safety concerns*, December 2021, p. 2, viewed 10 August 2022, <https://www.wa.gov.au/system/files/2021-12/Policy-Assessment-Investigation-Processes-Child-Safety-Concerns.pdf>.
[138] Department of Communities, *Policy on assessment and investigation processes for child safety concerns*, December 2021, p. 2, viewed 10 August 2022, <https://www.wa.gov.au/system/files/2021-12/Policy-Assessment-Investigation-Processes-Child-Safety-Concerns.pdf>.

with the referrer', 'checking the Department's records', and, when appropriate, 'contacting the person/s with parental responsibility'.[139] Additionally:

> … when FDV is identified, child protection workers must determine whether the Department has a role in assessing and responding to emotional abuse–FDV.
>
> Decisions about whether or not the Department has a role, should be informed by the following factors. As a general principle, a child's exposure to a single severe episode of violence or exposure to repeated episodes of violence over time, would both warrant intake for further investigation. Exposure can include witnessing or hearing acts of FDV or seeing physical injuries caused by FDV.
>
> Factors to consider when determining whether it is likely that a child has suffered significant harm or is likely to suffer significant harm in the future include:
>
> - the perpetrator's pattern of behaviour including the violent and abusive tactics used
> - the history, severity and frequency of the violence
> - the child's exposure and indications of emotional harm
> - the age and vulnerability of the child, and
> - factors impacting on the family which may increase vulnerability such as mental ill-health, substance misuse, chronic health issues, homelessness and social isolation.
>
> Where FDV has been identified and is not intaked for further assessment, a rationale for the decision must be recorded in the duty interaction. At every subsequent contact the need to undertake an assessment must be reviewed. Note that protectiveness of the adult victim is not sufficient reason for the Department to have no role when it is likely that there has been, or is likely to be, significant harm to a child.[140]

High-risk infants aged 0-2 years and children under 5 years are additionally assessed during an interaction to determine whether a priority investigative response within 24 hours (Priority 1) or within 2-5 working days (Priority 2) is required.[141]

8.1.2.2 Intake

'Intake' is the Department's process of opening a period of case management, and may occur at the end of an interaction in order for the Department of Communities to undertake initial inquiries, a child safety assessment, or provide financial assistance.

[139] Department of Communities, *Casework Practice Manual: 4.1 Assessment and investigation processes*, 6 February 2017, archived at <https://webarchive.nla.gov.au/awa/20170223075228/https://manuals.dcp.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=18>.
[140] Department of Communities, *Casework Practice Manual: 4.1 Assessment and investigation processes*, 6 February 2017, archived at <https://webarchive.nla.gov.au/awa/20170223075228/https://manuals.dcp.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=18>.
[141] Department of Communities, *Casework Practice Manual: 4.1 Assessment and investigation processes*, 6 February 2017, archived at <https://webarchive.nla.gov.au/awa/20170223075228/https://manuals.dcp.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=18>.

8.1.2.3 Initial inquiries

Where the Department of Communities assesses that a concern for a child's wellbeing has been raised during an interaction, and that the case should proceed to intake to obtain further information, initial inquiries are conducted 'to clarify the information received' and 'assess whether the Department has an ongoing role' in safeguarding or promoting the child's wellbeing.[142]

During an initial inquiry, information may be obtained from a broader range of sources, including 'other family members; the child's school; health and medical professionals; other government agencies; or with non-government services who may be working with the family and have relevant information.'[143]

Following these inquiries, the Department of Communities may a conduct a child safety investigation, offer to provide family support services or decline to take any further action and close the period of contact.

8.1.2.4 Child safety investigations

At the conclusion of an interaction or initial inquiries, the Department of Communities may undertake a child safety investigation (formerly known as a safety and wellbeing assessment or 'SWA') into alleged child abuse or neglect under section 32(1)(d) of the *Children and Communities Services Act 2004.* The purpose of a child safety investigation is:

> … to determine:
>
> - whether the child has experienced actual significant harm or is likely to experience significant harm as a result of the abuse and/or neglect;
> - the parent or parents' capacity to protect their child from harm; and
> - whether the child is in need of protection.[144]

In the context of a child safety investigation, 'significant harm' means:

> … any detrimental effect of a significant nature on the child's wellbeing, whether caused by –
>
> (a) a single act, omission or circumstance; or
>
> (b) a series or combination of acts, omissions or circumstances.[145]

Upon completion, a child safety investigation will record whether harm (or the likelihood of significant harm) has been 'substantiated' or 'not substantiated'.

[142] Department of Communities, *Casework Practice Manual: 4.1 Assessment and investigation processes*, 6 February 2017, archived at <https://webarchive.nla.gov.au/awa/20170223075228/https://manuals.dcp.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=186>.
[143] Department of Communities, *Policy on assessment and investigation processes for child safety concerns*, December 2021, p. 3, viewed 10 August 2022, <https://www.wa.gov.au/system/files/2021-12/Policy-Assessment-Investigation-Processes-Child-Safety-Concerns.pdf>.
[144] Department of Communities, *Policy on assessment and investigation processes for child safety concerns*, December 2021, viewed 10 August 2022, <https://www.wa.gov.au/system/files/2021-12/Policy-Assessment-Investigation-Processes-Child-Safety-Concerns.pdf>.
[145] *Children and Community Services Act 2004* (WA), s. 28(1).

8.1.2.5 Children in the care of the Department of Communities' Chief Executive Officer

If a child safety investigation determines that a child is 'in need of protection' within the meaning of section 28 of the *Children and Community Services Act 2004*, the Department of Communities can:

- make an application seeking a warrant (provisional protection and care) from the Children's Court under section 35 of the *Children and Community Services Act 2004;* or
- bring a child into provisional protection and care without a warrant when 'there is an immediate and substantial risk to the child's wellbeing' under section 37 of the *Children and Community Services Act 2004*.

When a child is brought into the care of the Department of Communities Chief Executive Officer (**CEO**) under section 35 or section 37 of the *Children and Community Services Act 2004*, the ASSIST case management system records the commencement of a 'period in the care of the CEO'.

8.2 The 13 children and young women known to the Department of Communities

Given the significant role of the Department of Communities in protecting children from harm arising from family and domestic violence, the Office conducted fieldwork as part of this investigation. Through this fieldwork, the office identified that the Department of Communities received information about the wellbeing of 13 of the 20 children and young women (65 per cent). These children and young women are referred to as the **13 children and young women known to the Department of Communities**.

The Office notes the limitations of our analysis of the Department of Communities contact with the 13 children and young women, particularly:

- contacts prior to the introduction of electronic filing and the ASSIST client management system in 2007-08; and
- recent reforms to introduce a centralised intake model and interaction risk assessment tool which occurred after the 2017.

The Office also notes the ongoing efforts by the Department of Communities to enhance family and domestic violence screening at all points of contact with children, young people and their families; and improve data collection and capture in its ASSIST client management system.

Of relevance to the Office's analysis, which was undertaken on data recorded prior to 31 December 2017, is the Department of Communities' *Casework Practice Manual* chapter on 'Conducting a Child Safety Investigation', which currently requires child protection workers to:

> … assume that family and domestic violence is a factor in all cases and screen out for this. As much as possible you should try to hold initial conversations with parents separately. This allows for FDV screening to occur, but also minimises the likelihood that the parents will influence each other's recall of events.[146]

The *Casework Practice Manual* also contains guidance on responding to interactions involving family and domestic violence, as follows:

> Decisions about whether the Department has a role in cases where a child has been exposed to family and domestic violence (FDV), **must** be informed by the following:
>
> - likelihood that a child has suffered significant harm or is at risk of significant harm
> - likelihood that an adult victim has suffered significant harm or is at risk of significant harm
> - the age and vulnerability of the child
> - the perpetrator's pattern of behaviour including history, severity and frequency of violent and abusive tactics, and the presence of evidence based risk indicators (or red flags), and
> - factors impacting on the family which may increase risk or vulnerability such as mental ill-health, substance misuse, homelessness and adult victim vulnerability.
>
> You **must** be aware that the protectiveness of the adult victim is not sufficient reason for us not to have a role when there is indication of significant harm to a child, or likely significant harm to a child.
>
> When a family presents on multiple occasions within a short period of time, the case **must** be intaked. If the case is not progressed to initial inquiry or child safety investigation (CSI), a rationale for this decision **must** be recorded and approved by your team leader. At every subsequent contact the need to undertake further assessment **must** be reviewed.[147] [original emphasis]

[146] Department of Communities, *Casework Practice Manual: 2.2.4 Conducting a child safety investigation*, 2 August 2022, viewed 10 August 2022, < https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=186>.
[147] Department of Communities, *2.3.1 Assessing emotional abuse - family and domestic violence*, 2 August 2022, viewed 10 August 2022, <https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=153>.

The Department of Communities has also revised its practice guidance regarding data capture and recording for family and domestic violence in ASSIST, which states that:

> Consistent recording of family and domestic violence in Assist is essential for the clear transmission of information as well as for data extraction and monitoring. …
>
> You **must** assume that family and domestic violence is a factor in the case, and seek information at the earliest opportunity to confirm or refute this assumption. This can include searching our records (including Assist, Objective and triage data bases), clarifying information with the referrer, or asking the child's mother (or other female caregiver) the family and domestic violence screening questions.
>
> Record the outcome of this inquiry in the 'initial assessment' field and include a brief description of the screening process (e.g. summary of relevant history or outcome of screening questions); and the decision regarding further assessment. Outcome options include:
>
> - no family and domestic violence identified;
> - family and domestic violence identified but no significant harm apparent; or
> - concern for a child, emotional abuse - family and domestic violence.
>
> Where a duty interaction relates to family and domestic violence, there are two primary issue selections that could be recorded from the 'Primary Issue' drop-down list, either:
>
> - domestic violence; or
> - child protection.
>
> When 'child protection' is selected it is essential that the abuse type recorded for the child is 'emotional abuse – family and domestic violence'. For the child's parents, the issue and/or detail should be recorded as 'family and domestic violence'.[148]

The Department of Communities has also clarified when caseworkers should record new referrals relating to an investigation that is already underway, as follows:

> Receiving new concerns to an open investigation
>
> If you are already undertaking an investigation in relation to a child and you receive new concerns for that child, in consultation with a team leader, you should decide if a new interaction is recorded or if the new concern is addressed as part of the current open investigation.

[148] Department of Communities, *2.3.1 Assessing emotional abuse - family and domestic violence*, 2 August 2022, viewed 10 August 2022, <https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=153>.

If…	Then…
The new referral contains information regarding the same abuse type as the current open investigation	The referral can be recorded as additional information and addressed as part of the current investigation
The new referral contains information significantly different from the current open investigation or in relation to a different relative	The referral should be recorded as a new interaction and an intake

> The decision about recording a new referral as additional information or as a new investigation is made in consultation with the relevant team leader, yours, and/or the team leader responsible for the current investigation.[149]

The Office notes that for most of the interactions considered in the following analysis, the requirements set out above were not yet in place, with the *Casework Practice Manual* instead stating (as recently as March 2015) that:

> Family and domestic violence is often the underlying but hidden cause for client contact with the Department for Child Protection and Family Support (the Department), particularly in requests associated with crisis accommodation, financial assistance and information and referral. Family and domestic violence also has a high co-occurrence with all forms of child abuse and maltreatment, in particular neglect and emotional abuse.
>
> Where family and domestic violence is present but not identified in child protection work assessment of past harm and likely future danger to the child and adult victim is unlikely to be accurate and the effectiveness of safety planning may therefore be compromised. …
>
> Child protection workers should make a professional judgement about when to screen for family and domestic violence – this judgement is informed by the presenting issue as well as the presence of indicators of family and domestic violence.[150]

[149] Department of Communities, *Casework Practice Manual: 2.2.4 Conducting a child safety investigation*, 2 August 2022, viewed 10 August 2022, < https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=186>.
[150] Department for Child Protection and Family Support, *Casework Practice Manual: 5.1 Family and Domestic Violence Screening and Assessment*, 14 November 2014, 1 March 2015 archive available at: <https://webarchive.nla.gov.au/awa/20150228214918/http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/01FamilyandDomesticViolenceScreeningandAssessment.aspx>.

8.3 Contact between the Department of Communities and the 13 children and young women

8.3.1 The Department of Communities received information about the wellbeing of 13 children and young women who died by suicide in 201 interactions

Through the fieldwork undertaken during this investigation, the Office identified that the Department of Communities received information that raised concerns about the wellbeing of 13 children and young women who died by suicide through 201 interactions, as shown in Figure 8.

These figures exclude an additional 48 interactions record in relation to the 13 children and young women, where data relating to the 'primary issue' and 'outcomes' fields was:

- not entered; or
- recorded as 'Migrated Data' arising from the Department of Communities shift to a new case management system in March 2010.

8.3.2 All of the 13 children and young women were the subject of multiple referrals to the Department of Communities

The Department of Communities received a total of 201 interactions or referrals about the 13 children and young women who died by suicide. On average, the 13 children and young women came to the attention of the Department of Communities on 15 occasions, with the number of contacts ranging from two to 58 occasions.

All of the 13 children and young women were the subject of multiple referrals to the Department of Communities. However, a number of children and young women were the subject of significantly more contact with the Department. In particular, the Office found that, of the 13 children and young women:

- seven were the subject of over ten interactions; and
- two were the subject of over 40 interactions.

Figure 8: Department of Communities contact with the 13 children and young women known to the Department of Communities

	Interactions (all)	Interaction (under 18 years)	Interactions (18-25 years)	Initial Inquiries	Child Safety Investigations	Substantiations of harm	In care of the CEO during lifetime
Child 1	4	4	0	0	0	0	No
Child 2	29	29	0	5	6	4	Yes
Child 3	58	58	0	11	12	6	Yes
Child 4	3	3	0	1	0	0	No
Child 5	2	2	0	0	0	0	No
Child 6	3	3	0	1	1	0	No
Child 7	11	11	0	1	0	0	No
Young woman 1	42	32	10	0	0	0	No
Young woman 2	7	0	7	0	0	0	No
Young woman 3	4	4	0	0	0	0	No
Young woman 4	17	3	14	0	1	0	No
Young woman 5	4	2	2	0	0	0	No
Young woman 6	17	15	2	1	0	0	No
Total	**201**	**166**	**35**	**20**	**19**	**10**	**2**

Source: Ombudsman Western Australia

8.3.3 Four of the 13 children and young women known to the Department of Communities were the subject of a Child Safety Investigation as children

The Department of Communities' *Casework Practice Manual* identifies that a Child Safety Investigation (formerly known as a Safety and Wellbeing Assessment) 'is undertaken by authorised officers from the Department of Communities' and 'is conducted under the provisions of Section 31 and 32 of the *Children and Community Services Act 2004.*'[151]

[151] Department of Communities, 'Casework Practice Manual: 2.2.4 Conducting a Child Safety Investigation,' Government of Western Australia, Perth, 2021, viewed 26 February 2021 <https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=186>.

The Office identified that four of the children and young women who had contact with the Department of Communities were the subject of a Child Safety Investigation. These children and young women were the subject of 19 Child Safety Investigations in total, with two being the subject of multiple investigations.

Two children were 1 year old at the time a Child Safety Investigation was conducted into their wellbeing, with another child being the subject of an investigation at the age of 12 years.

8.3.4 Two of the children were in the care of the Chief Executive Officer at the time they died by suicide

If the Department of Communities believes a child to be in need of protection based on the criteria listed under section 28(2) of the *Children and Community Services Act 2004*, it may make an application to the Children's Court for a protection order.

Of the 13 children and young women known to the Department of Communities, two were the subject of a protection order that resulted in them being in the care of the Chief Executive Officer of the Department of Communities at some time in their lives. Both of these children were Aboriginal and/or Torres Strait Islander and were in the care of the Chief Executive Officer at the time they died by suicide.

8.4 Patterns and trends in contact between the Department of Communities and the 13 children and young women

8.4.1 Family and domestic violence was the second most frequently recorded primary issue in the 201 interactions for the 13 children and young women known to the Department of Communities

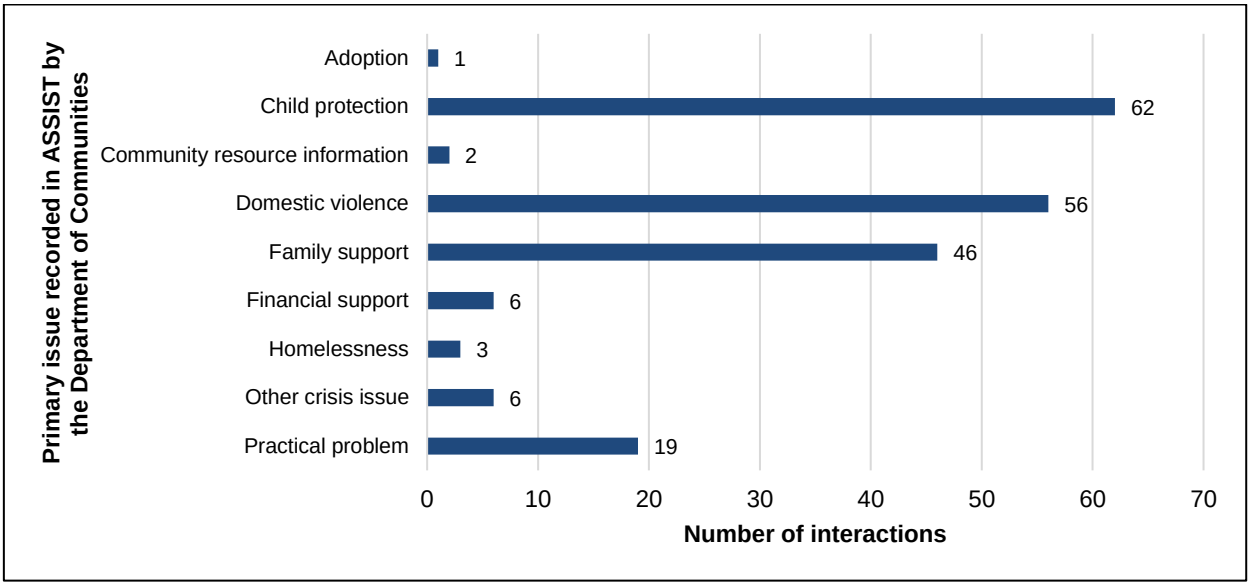
Department of Communities' staff are required to enter a 'primary issue' for each interaction recorded in the ASSIST system, selected from the following categories:[152]

- adoption;
- child protection;
- community resource information;
- domestic violence;
- family support;
- financial support;
- fostering issue;
- homelessness;
- interstate liaison;
- interstate transfer;
- other crisis issue; and
- practical problem.

The primary issue recorded for each of the 201 interactions between the Department of Communities and the 13 children and young women are shown in Figure 9:

[152] Department of Communities, *Casework Practice Manual: 2.2.2 Processing referrals and interactions*, 17 February 2022, archived on 7 March 2022 at <https://webarchive.nla.gov.au/awa/20220306182053/https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=290>.

Figure 9: Primary issue recorded by the Department of Communities in 201 interactions relating to the 13 children and young people



Source: Ombudsman Western Australia

The Office identified that, of the 201 interactions received about the 13 children and young women known to the Department of Communities, 'domestic violence' was the second most frequently recorded primary issue (56 interactions, or 28 per cent of interactions).

8.4.2 Family and domestic violence was the most frequently recorded 'other' issue among the 201 interactions for the 13 children and young women known to the Department of Communities

Up to five other issues can also be recorded concurrently with the primary issue in ASSIST for each interaction. Accordingly, the Office analysed the other issues recorded in ASSIST for the 201 interactions for the 13 children and young people, as shown in Table 24.

Table 24: Other issues recorded in the 201 interactions for the 13 children and young people known to the Department of Communities

Issue	Occasions
Adoption	1
Alcohol	1
Child concern report	7
Custody access	7
Emotional harm	6
Family domestic violence	59
Family problem	30
Financial problem	8
Homelessness	4
Housing issue	1
Medical problem	9
Neglect	4
Parent/adolescent conflict	9
Parenting	13
Physical harm/abuse	8
Post trauma support	1
Psychological problem	4
Request for information	3
Sexual harm	16
Substance abuse	9
Suicide risk	1

Source: Ombudsman Western Australia

8.4.3 The Department of Communities recorded family and domestic violence as an issue in 66 of the 201 interactions relating to the 13 children and young women

The Office found that the Department of Communities identified family and domestic violence in a total of 66 of the 201 interactions relating to the 13 children and young women as follows:

- domestic violence was recorded as the primary issue in 56 interactions; and
- family and domestic violence was recorded within the other issues fields of an additional 10 interactions (under the primary issues of child protection, other crisis issue and practical problem).[153]

8.4.4 The Office identified family and domestic violence in 110 of the 201 interactions relating to the 13 children and young people

The Office reviewed the information provided to the Department of Communities in each interaction to identify whether the free-text information recorded in ASSIST described any

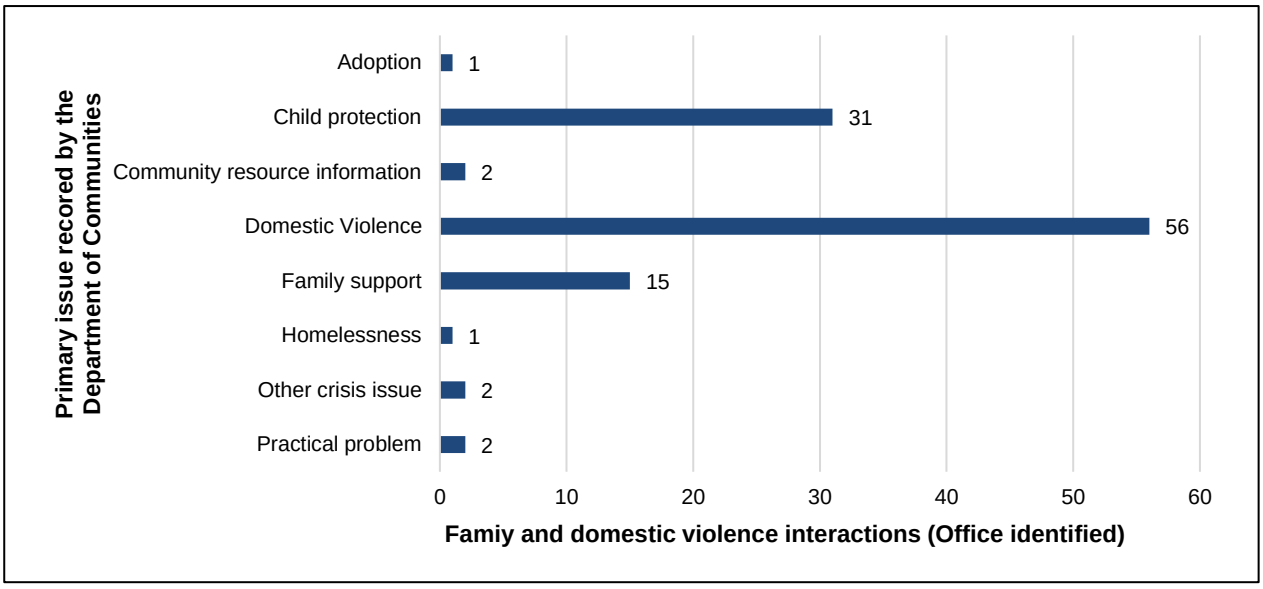
[153] The Office notes that 48 interactions with domestic violence as the primary issue had 'family and domestic violence' recorded in the 'Issue (other) 1' field and that 1 interaction had family and domestic violence recorded in the other issues (1) and (2) fields.

acts of family and domestic violence. For example, the Office identified family and domestic violence as an issue when an interaction recorded that:

- a caregiver 'disciplined' a child with 'a beating … [to] sort her out' or by hitting the child's head with a metal pole, (the issues recorded in ASSIST were 'child protection – runaway child' and 'physical harm/abuse – excessive discipline');
- a refuge called Crisis Care for assistance to transport a young woman to hospital for treatment of a broken arm, (the issue recorded in ASSIST was 'family support – medical problem');
- a family member reported concerns that a mother's boyfriend of one month was isolating her and her child and preventing them from having any contact with family members (the issue recorded in ASSIST was 'custody access – parent'); and
- a 'runaway' child reported to the Police that they were 'too frightened to return home at all' due to a step-father's verbal put-downs and punishments of locking them in their room and hitting them repeatedly with a belt until they were 'no longer able to stand' and 'fell on the floor' (the issue recorded in ASSIST was 'family problem – immediate family').

The Office identified that 'family support' was the third most frequently used primary issue recorded in interactions containing details of alleged family and domestic violence. Details of the primary issue recorded by the Department of Communities in the 110 interactions for the 13 children and young people where the Office identified family and domestic violence are shown in Figure 10.

Figure 10: Primary issue recorded in the 110 family and domestic violence interactions identified by the Office, for the 13 children and young women known to the Department of Communities



Source: Ombudsman Western Australia

The Office also considered the other issues recorded in ASSIST for the 110 family and domestic violence interactions identified by the Office, relating to the 13 children and young people known to the Department of Communities, as shown in Table 25.

Table 25: Other issues recorded for the 110 family and domestic violence interactions identified by the Office, for the 13 children and young people known to the Department of Communities

Issue	Occasions
Alcohol	1
Emotional abuse	1
Family Problem	1
Homelessness	1
Medical problem	1
Parent/adolescent conflict	3
Parenting	2
Physical harm/ abuse	5
Substance abuse	6
Suicide risk	1

Source: Ombudsman Western Australia

8.4.5 The Department of Communities recorded the outcome of 'not departmental business' or 'assessed as no further role' in 35 per cent of interactions where the Office identified family and domestic violence

The Office reviewed the recorded outcome for each of the 201 interactions received about the 13 children and young people known to the Department of Communities to compare:

- the outcomes of the 66 interactions where the Department of Communities recorded family and domestic violence as a 'primary issue' or 'issue' in ASSIST; and
- the outcomes of the 110 interactions where the Office identified that information had been received concerning the 13 children and young people and alleged family and domestic violence (Table 26).

Table 26: Outcomes recorded for interactions involving the 13 children and young people known to the Department of Communities, by family and domestic violence status

Outcome	Number of interactions where the Department of Communities identified FDV	Number of interactions where the Office identified FDV	Total interactions for the 13 children and young women
Adoption management	0	1	1
Assessed as no further role	15	16	16
Concern for child	12	33	61
Family support	20	34	80
Financial assistance	1	1	8
Not departmental business	17	22	29
Parent Support referral	1	3	6
Total	**66**	**110**	**201**

Source: Ombudsman Western Australia

Arising from this analysis, the Office identified that the Department of Communities recorded the outcome as:

- **concern for child** in 18 per cent of interactions where it recorded family and domestic violence as an issue in ASSIST, compared to 30 per cent of interactions where the Office identified family and domestic violence and 30 per cent of the 201 interactions involving the 13 children and young people;
- **family support** in 30 per cent of interactions where it recorded family and domestic violence as an issue in ASSIST, compared to 31 per cent of interactions where the Office identified family and domestic violence and 40 per cent of the 201 interactions involving the 13 children and young people; and
- **not Departmental business** or **assessed as no further role** in 48 per cent of interactions where it recorded family and domestic violence as an issue in ASSIST, compared to 35 per cent of interactions where the Office identified family and domestic violence and 22 per cent of the 201 interactions involving the 13 children and young people.

8.4.6 Of the 110 interactions relating to the 13 children and young women where the Office identified family and domestic violence, the Department of Communities progressed to intake for additional actions on 26 occasions (27 per cent)

As shown in Figure 11, the Department of Communities progressed interactions regarding the 13 children and young women to intake on 50 occasions (25 per cent). For comparison, the Department of Communities progressed to intake interactions where:

- the Office identified family and domestic violence on 26 occasions (24 per cent of 101 interactions); and
- 'family and domestic violence' was recorded as an issue in ASSIST on eight occasions (12 per cent of 66 interactions).

Figure 11: The Department of Communities' next actions for interactions regarding the 13 children and young women, by family and domestic violence status

Next Action	Number of interactions where the Department of Communities identified FDV	Number of interactions where the Office identified FDV	Total interactions for the 13 children and young women
Not recorded	1	10	43
Intake	8	26	50
No further action	56	82	147
Referral to support service	1	1	1
Unable to proceed	1	1	3
Total	**66**	**110**	**201**

Source: Ombudsman Western Australia

Also shown in Figure 11 is the Office's consideration of the next action recorded for each of interactions involving the 13 children and young women known to the Department of Communities where:

- the Office identified family and domestic violence (110 interactions); and
- the Department of Communities recorded family and domestic violence as an issue in ASSIST.

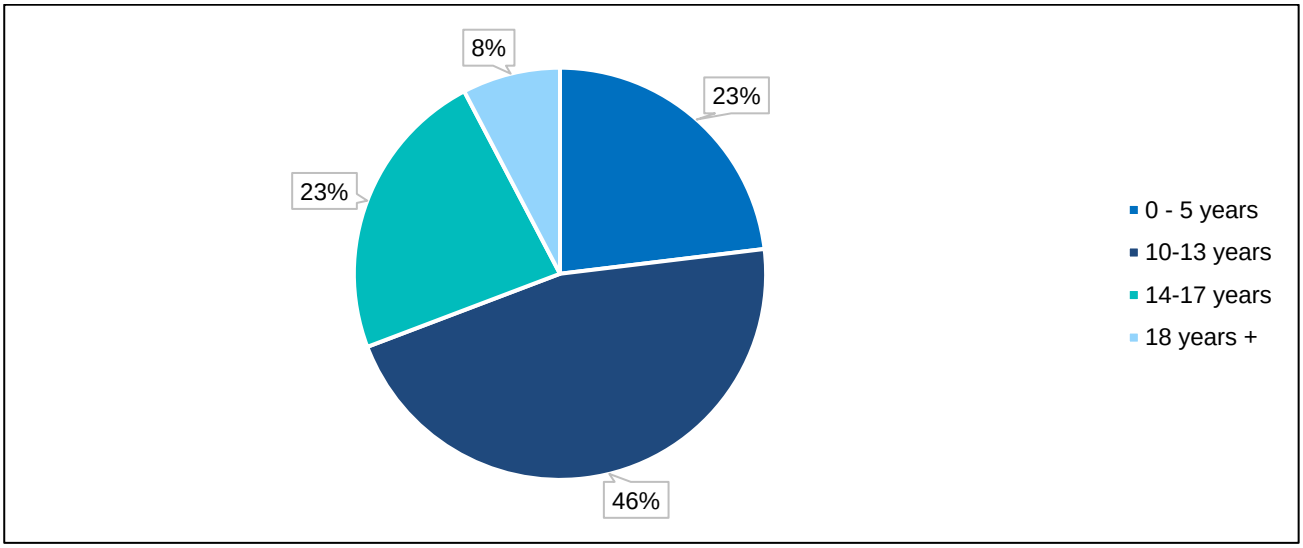
Arising from this analysis, the Office identified that that the Department of Communities recorded the 'next action' of family and domestic violence related interactions as:

- **intake** in 12 per cent of interactions where it recorded family and domestic violence as an issue in ASSIST, compared to 27 per cent of interactions where the Office identified family and domestic violence and 25 per cent of the 201 interactions involving the 13 children and young people; and
- **no further action** in 85 per cent of interactions where it recorded family and domestic violence as an issue in ASSIST, compared to 75 per cent of interactions where the Office identified family and domestic violence and 73 per cent of the 201 interactions involving the 13 children and young people.

8.4.7 Nine of the 13 children and young people known to the Department of Communities were first in contact with the Department as a child between the ages of 0 and 13 years

The Office analysed Department of Communities contact concerning the 13 children and young women known to the Department of Communities and identified that they had contact with the Department of Communities across the course of their lives.

Figure 12: Age at first contact with the Department of Communities, for the 13 children and young people who died by suicide



Source: Ombudsman Western Australia

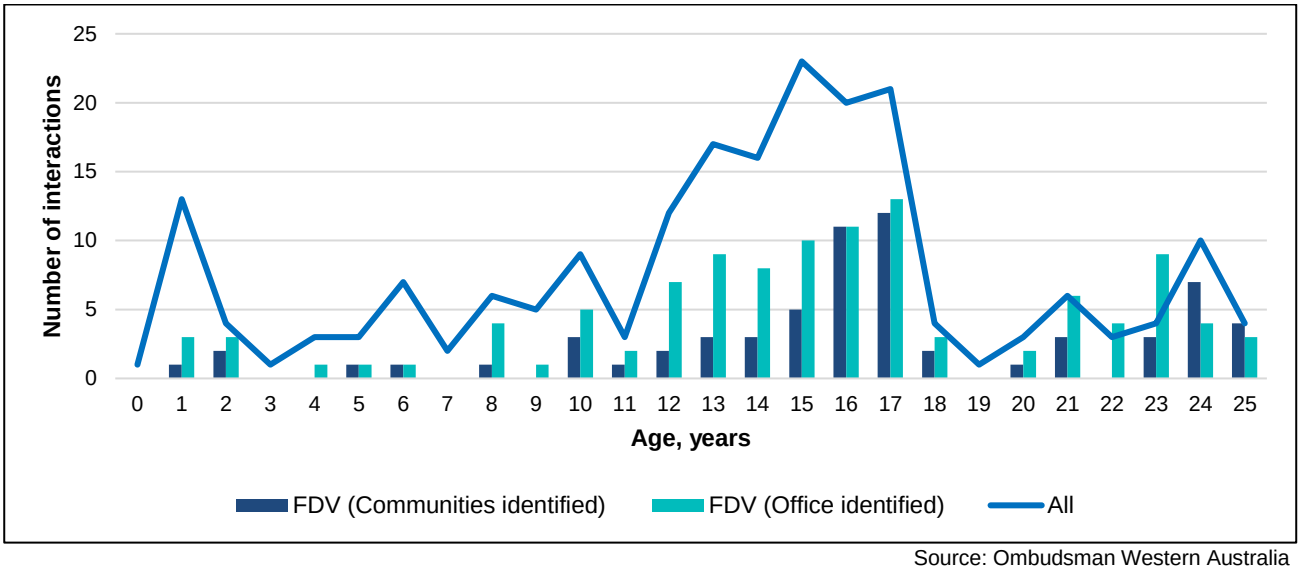
As shown in Figure 12, the Office identified that, of the 13 children and young women known to the Department of Communities:

- nine first become known to the Department between the ages of 0 and 13 years (69 per cent), including:
    - three children who died by suicide whose first contact was between the ages of 0 and 5 years (23 per cent); and
    - four children and two young women whose first contact was between the ages of 10 and 14 years (31 per cent);
- three became known to the Department, between the ages of 14 and 15 years (23 per cent); and
- one young woman who first became known to the Department at the age of 21 years, regarding an enquiry to formalise her guardianship of a child in her care.

8.4.8 Referrals to the Department of Communities regarding the 13 children and young women occurred most frequently at age one and between the ages of 14 and 17 years

As shown in Figure 13, the Office identified peaks in Department of Communities' interactions with the 13 children and young women at age 1 and between the ages of 14 and 17 years.

Figure 13: Interactions for the 13 children and young women, by age and family and domestic violence status



Source: Ombudsman Western Australia

Of the 201 interactions with the 13 children and young women:

- 18 occurred in the first 1,000 days of childhood (pre-birth until the child's third birthday);
- 7 occurred between the ages of 3 to 5 years;
- 20 occurred between the ages of 6 to 9 years;
- 41 occurred between the ages of 10 to 13 years;
- 80 occurred between the ages of 14 to 17 years; and
- 35 occurred between the ages of 18 to 25 years.

Arising from this analysis, the Office identified that referrals to the Department of Communities for the 13 children and young women occurred most frequently:

- initially at age one (13 interactions, six per cent of the 201 interactions); and
- subsequently between the age of 14 and 17 years (80 interactions, 40 per cent).

8.4.9 Family and domestic violence related interactions for the 13 children and young women occurred most frequently between the ages of 10 and 13 years and again between the ages of 14 and 17 years

The Office further analysed the interactions in which the Department of Communities recorded family and domestic violence as an issue in ASSIST together with the interactions where the Office had identified family and domestic violence for the 13 children and young women according to their age at the time of the interaction.

As shown in Figure 13, the Office identified that referrals to the Department of Communities containing alleged family and domestic violence occurred throughout the lives of the 13 children and young people, peaking between the ages of 10 to 13, and again between the ages of 14 to 17 years.

Of the 110 family and domestic violence related interactions with the 13 children and young women identified by the Office:

- 6 occurred in the first 1,000 days of childhood (pre birth until the child's third birthday);
- 2 occurred between the ages of 3 to 5 years;
- 6 occurred between the ages of 6 to 9 years;
- 23 occurred between the ages of 10 to 13 years;
- 42 occurred between the ages of 14 to 17 years; and
- 31 occurred between the ages of 18 to 25 years.

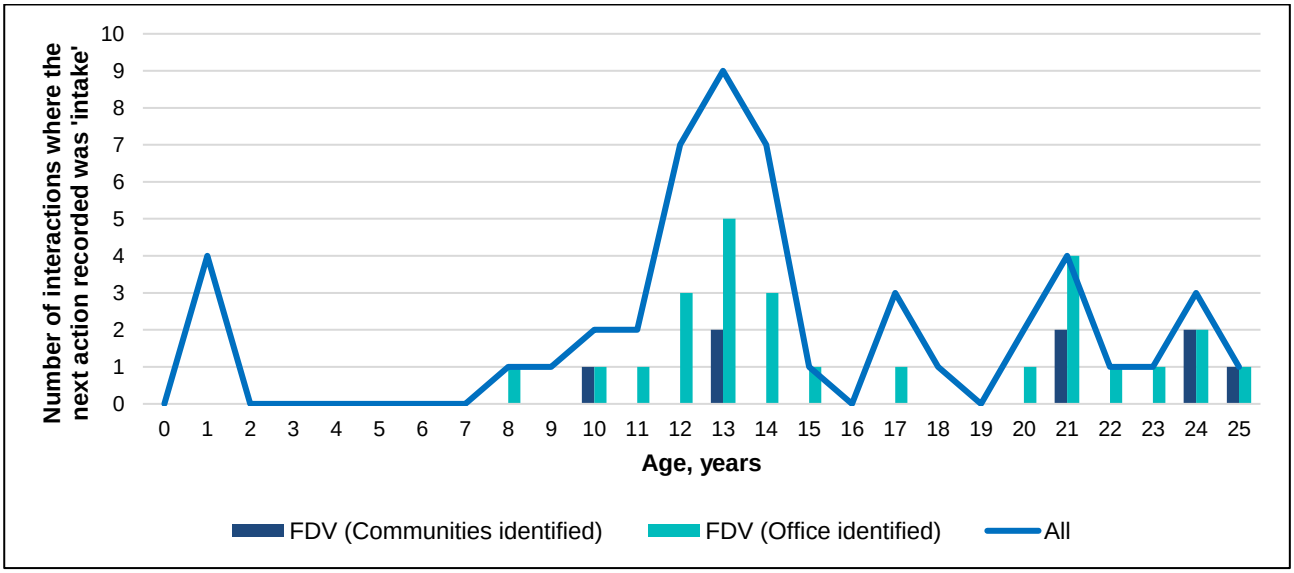
Arising from this analysis, the Office identified that referrals to the Department of Communities for the 13 children and young women regarding family and domestic violence occurred most frequently between the ages of:

- 10 and 13 years (23 interactions, 21 per cent of the 110 interactions); and
- 14 and 17 years (42 interactions, 38 per cent).

8.4.10 Intake of concerns for the 13 children and young people by the Department of Communities occurred most frequently at ages 1 and 13. Intake of interactions occurred most frequently at age 1 and between the ages of 10 to 13 years.

As shown in Figure 14, the Office identified peaks in Department of Communities' intake of interactions regarding the 13 children and young women at age 1 and between the ages of 10 and 13 years.

Figure 14: Intake for the 13 children and young women, by age and family and domestic violence status



Source: Ombudsman Western Australia

Of the 50 interactions with 'intake' recorded as their next action related to the 13 children and young women:

- four occurred in the first 1,000 days of childhood (pre birth until the child's third birthday);
- zero occurred between the ages of 3 to 5 years;
- two occurred between the ages of 6 to 9 years;
- 20 occurred between the ages of 10 to 13 years;
- 11 occurred between the ages of 14 to 17 years; and
- 13 occurred between the ages of 18 to 25 years.

Arising from this analysis, the Office identified that referrals to the Department of Communities for the 13 children and young women occurred most frequently:

- initially at age one (four interactions, eight per cent of the 50 intakes); and
- subsequently between the age of 10 and 13 years (20 interactions, 40 per cent).

Figure 14 also shows that intake of family and domestic violence related interactions for the 13 children and young women peaked at age 1 and at age 13.

Of the 26 family and domestic violence interactions (as identified by the Office) that progressed to intake for the 13 children and young women:

- zero occurred in the first 1,000 days of childhood (pre birth until the child's third birthday);
- zero occurred between the ages of 3 to 5 years;
- one occurred between the ages of 6 to 9 years;
- 10 occurred between the ages of 10 to 13 years;
- five occurred between the ages of 14 to 17 years; and
- 10 occurred between the ages of 18 to 25 years.

Arising from this analysis, the Office identified that intake by the Department of Communities of family and domestic violence related referrals for the 13 children and young women

occurred most frequently between the ages of 10 and 13 years (10 interactions, 38 per cent of the 26 family and domestic violence related interactions identified by the Office that progressed to intake).

8.5 Opportunities to improve data collection about children's experiences of family and domestic violence

8.5.1 Children have a right to freely express their views in all matters affecting them

Article 12 of the *Convention on the Rights of the Child,* identifies that children have a right to express their views in all matters affecting their lives:

> Article 12
>
> 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.[154]

8.5.2 Knowledge about children's experiences of family and domestic violence is limited

Researchers identify that inconsistent documentation of family and domestic violence across state jurisdictions and statutory agencies 'makes it difficult to collect meaningful data about patterns and levels of [family and domestic violence] and to gauge effective interventions.'[155] These limitations in data collection affect the efficacy of 'responses to cases involving DFV as they do not know the full extent and nature of the problem.'[156]

The research literature notes the difficulty of obtaining 'complete and robust data on children's exposure to family violence' arises from barriers such as:

> … the sensitivity of the subject, with administrative sources only able to identify reported cases and most large-scale population surveys focusing on adult experiences and/or their perceived knowledge of child experiences.
>
> While administrative data collections, such as police and hospital data, can provide some insights, these data sources are likely to underestimate the true extent of children exposed to family violence, with many children (and non-perpetrating parent/guardians) reluctant to report family violence to the police or seek necessary medical attention.
>
> To enhance current administrative data on family violence, the identification and collection of data on family violence in other routinely collected administrative data sources is important. Improvements to existing collections, for example child protection, specialist homelessness services, and perinatal, are underway.
>
> To supplement administrative data, the First national study of child abuse and neglect in Australia, being conducted from 2019–2023, may provide additional insight into family violence by retrospectively reporting on childhood experiences

[154] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), Art 12.
[155] Australian National Research Organisation for Women's Safety, *The impacts of domestic and family violence on children*, 2018, ANROWS, Sydney, 2018, p. 3.
[156] Cahill A, Stewart J and Higgins D, *Service system responses to children and young people in the statutory child protection system who have experienced or witnessed family violence,* 2020, Institute of Child Protection Studies, Australian Catholic University, Canberra, p. 20.

> of family violence for respondents aged 16 and over. In addition to collecting data on childhood experiences retrospectively, data collected directly from children is also important.[157]

8.5.3 Expanding the evidence of children and adolescents' experiences of family and domestic violence is crucial

Comprehensive data collection about children's experiences and perceptions of family and domestic violence is crucial in underpinning the development of services intended to assist children affected by family and domestic violence.

Building the evidence base of data on family and domestic violence in Australia has also been identified as a foundation for change under *Australia's National Plan to Reduce Violence against Women and their Children 2010-2022* (**the National Plan**):

> The National Plan … recognises the need for a strong evidence base to inform the development of appropriate, targeted strategies to reduce these forms of violence and for evaluation of action taken. The current evidence base is not sufficiently robust to support the information requirements of governments to achieve the aims of their coordinated response, now and into the future …
>
> An evidence base can provide a range of information that reflects the lived experience of individuals involved in and affected by incidents of family, domestic and sexual violence. This information can relate to the socio-demographic characteristics of offenders and victims (such as their age, education levels, income, health status, family composition and housing tenure), through to details of incidents, how they occur and responses to those incidents. Those affected by family, domestic and sexual violence may engage with a range of agencies, individuals and services, however this information can be fragmented. These pieces of information, when harnessed for analytical purposes can provide valuable insights that can be used to identify those at risk of family violence and deploy effective prevention, intervention and support strategies.[158]

The National Plan identifies 'build[ing] the evidence base to inform responses to domestic, family and sexual violence by strengthening the focus on what works to reduce violence, improving data and supporting the Fourth Action Plan priorities'[159] as a key action in improving support and service system responses to family and domestic violence.

Australia's National Research Organisation for Women's Safety have also highlighted that further research on the experiences of children and young people affected by family and domestic violence is needed '[t]o develop tailored services that are age-appropriate, … [and] investigate the nature, experience and impacts of childhood exposure to [family and domestic violence].[160]

[157] Australian Institute of Health and Welfare, *Australia's Children*, 2020, Australian Government, Canberra, p. 342.
[158] Australian Bureau of Statistics, *Defining the data challenge for family, domestic and sexual violence: Summary 2013*, 2013, viewed 15 June 2020, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4529.0.00.001main+features32013>.
[159] Council of Australian Governments, *Fourth Action Plan – National Plan to Reduce Violence against Women and their Children 2010-2022*, 2019, Commonwealth of Australia, Canberra, p. 6, 36.
[160] Australia's National Research Organisation for Women's Safety, *Australia's National Research Agenda to Reduce Violence against Women and their Children: ANRA 2020-2022*, 2020, ANROWS, Sydney, p. 8.

8.5.4 Systemic issues in data collection systems and recording practices in Australian jurisdictions have prevented children from being seen as victims of family and domestic violence in their own right

Academics, governments, advocates, parents and the former National Children's Commissioner have highlighted the urgent need to capture data directly from children about their experiences of family and domestic violence.[161] The New South Wales Government identified the importance of considering children as 'victims in their own right' and changing 'relevant data sets across the areas of child protection, health, housing, and police and justice systems' to record when children are 'a victim [of violence] or the recipient of services or service referrals', noting that:

> Better and wider flagging of domestic and family violence at program level across the service system (for example, as a vulnerability where children and families are accessing or affected by services) would build our understanding of how children are affected by domestic and family violence.[162]

In Victoria, a key theme that emerged from the *Royal Commission into Family Violence*, completed in 2016, was that children and young people experiencing family and domestic violence should be recognised as victim survivors in their own right. The Victorian Government's *Victorian Family Violence Data Collection Framework* identifies significant missed opportunities arising from gaps in data collection about children's experiences of family domestic violence, as including difficulties in:

> … know[ing] the extent, nature and outcomes of family violence on this population. It will also be difficult to consider important demographic details about these victims, including whether they belong to other priority communities, and to track the trajectory of these individuals through service data over time …[163]

8.5.5 The Australian research literature highlights a need to improve service system practice and recording so that information gathered directly from children experiencing family and domestic violence is used to enhance responses to family and domestic violence

The AIHW states that 'data collected directly from children is also important,'[164] noting that 'additional, regular, national data on the child's perspective of safety is essential for more complete understanding, and evidence suggests that children want to discuss their personal challenges and experiences.'[165]

[161] See for example, the submissions extracted in National Children's Commissioner, *Children's Rights Report 2015*, 2015, Australian Human Rights Commission, Sydney, p. 119.
[162] New South Wales Government, Submission No 51 to Australian Human Rights Commission, *National Children's Commissioner's examination into children affected by family and domestic violence*, 28 July 2015, p. 11.
[163] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, p. 41.
[164] Australian Institute of Health and Welfare, *Australia's Children*, Australian Government, Canberra, 2020, p. 342.
[165] Australian Institute of Health and Welfare, *Australia's Children*, Australian Government, Canberra, 2020, p. 304.

The Victorian *Family Violence Data Collection Framework* also highlights the importance of collecting information directly from children 'whenever possible and appropriate' in order to respect their:

> … right to have a say and be heard [and acknowledge] their role as a victim who has experienced family violence, even in circumstances where the violence was indirect. Gathering information directly from the victim will also provide insight on how children and young people uniquely experience family violence.[166]

8.5.6 Best practice information gathering from children about their experiences of family and domestic violence requires careful consideration of the child's needs, including the need to keep the child safe, and a tailored methodological approach

Researchers note that collecting information from children and adolescents that 'accurately and authentically reflects their experience can be difficult.'[167] The Australian Institute of Family Studies' Communities and Families Clearinghouse identifies four challenges services may experience when collecting data directly from children, as follows:

- *context*—children will respond differently depending upon the environment in which they are interviewed; a "natural" environment (such as a playground) is preferable to a formal interview room;
- *method of data gathering*—the method that is used needs to be considered in relation to the age of the child and their skills and capabilities;
- *ethical issues*—care should be taken to factor in vulnerability and potential harm for children from their involvement in data collection processes, recalling incidents of conflict for example may cause distress to a child; and
- *privacy and confidentiality*—assuring children that any data collected will be kept confidential is especially important because of the power imbalance between children and adults, however in some cases there may be instances when the information a child discloses needs to be reported (e.g., reports of child abuse).[168]

The AIFS notes that the most important factor in gathering information from children is 'building and maintaining relationships of trust with families' and also 'outlines four key methods that child and family services can use to assist the process of data collection', which are:

- become familiar with culturally competent evaluation;
- be aware of issues relating to consent, privacy and confidentiality when collecting data from children;
- become familiar with techniques for collecting data from children; and
- involve … children in the evaluation process.[169]

[166] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, p. 42.
[167] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, p. 42.
[168] McDonald M and Rosier K, *Collecting data from parents and children for the purpose of evaluation: Issues for child and family services in disadvantaged communities*, 2011, Australian Institute of Family Studies, Communities and Family Clearinghouse Australia, p. 3.
[169] McDonald M and Rosier K, *Collecting data from parents and children for the purpose of evaluation: Issues for child and family services in disadvantaged communities*, 2011, Australian Institute of Family Studies, Communities and Family Clearinghouse Australia, p. 4.

The *National Statement on Ethical Conduct in Human Research* also raises particular ethical considerations when undertaking research involving children and young people, including:

- their capacity to understand what the research entails, and therefore whether their consent to participate is sufficient for their participation;
- their possible coercion by parents, peers, researchers or others to participate in research; and
- conflicting values and interests of parents and children.[170]

Additionally, the *National Statement on Ethical Conduct in Human Research* provides guidelines for the design, ethical review and conduct of research undertaken with children and young people informed by the values of 'research merit and integrity', 'justice', 'beneficence', 'respect', 'standing parental consent' and the 'best interests of the child.'[171]

The Victorian *Family Violence Data Collection Framework* approach combines elements of both the AIFS and *National Statement on Ethical Conduct in Human Research* guidelines and notes that the following issues should be kept in mind when collecting data from children about their experiences of family and domestic violence:

- **Issues of privacy and confidentiality** are especially significant when collecting information from or about children and young people. The recent introduction of [data collection schemes] impact privacy and confidentiality, and organisations should be clear about their obligations and authorisations under those schemes. Staff should also prepare for the possibility that a child or young person may disclose information which is subject to mandatory reporting or may be shared to assess or manage family violence risk or promote safety and wellbeing and ensure that the child or young person understands the limitations of privacy and confidentiality.
- **Ethical issues**: Care should be taken to factor in vulnerability and potential harm from collecting data directly from a child. Where a child or young person has been a victim of family violence, being asked to specifically recall incidents may cause distress to the child or young person. Data collection should therefore consider sympathetic methodologies, appropriate contexts, protocols and procedures which enable data collectors to prepare for and manage the potential for risk and re-traumatisation.
- **The age of the child**: Collecting data directly from young children (6 years or under) which accurately reflects their experiences can be difficult, as they may not respond to traditional data collection methods (for example, surveys, interviews with strangers). Agencies and service providers should be aware of issues surrounding the age at which a child can consent to directly provide information which is captured in data.
- **The method used to gather data** should be considered depending on the age, developmental stage, skills and capabilities of a child. Written data collection for instance may not be appropriate if a child or young person is not comfortable with reading and writing. Similarly if a form is lengthy a child or young person may not have the attention span to complete the document. Non-traditional methods of data collection may make it easier to collect information and may make the process more effective for young children.

[170] National Health and Medical Research Council, Australian Research Council, and Universities Australia, *National Statement on Ethical Conduct in Human Research*, 2018, National Health and Medical Research Council, Canberra, p. 65.
[171] National Health and Medical Research Council, Australian Research Council, and Universities Australia, *National Statement on Ethical Conduct in Human Research*, 2018, National Health and Medical Research Council, Canberra, p. 65-67.

- **Children and young people are more affected by leading questions** and effort should be made to ensure that an interview is not intentionally or unintentionally leading a child or young person to certain answers. It should be made clear when working with children and young people that there are no correct or incorrect responses when speaking about their experiences.
- **Children and young people given the option to have a parent present or not present**: Wherever possible, children and young people should be given the option as to whether they would prefer to have a non-offending parent or guardian present when participating in interviews. A child's answers to questions may vary depending on whether a parent or guardian is present. Data collectors should also be mindful in the context of family violence to consider the possibility that a parent or guardian is the perpetrator of abuse. In this circumstance it would not be appropriate to gather information from a child or young person with that parent or guardian present.[172]

Recommendation 3: The Department of Communities, working together with relevant State government departments and authorities and stakeholders, identify strategies and practices for identifying, recording, and utilising information about children and adolescents' experiences of family and domestic violence. Including, but not limited to:

- the number of children affected by family and domestic violence in Western Australia;
- the nature of how children and adolescents experience family and domestic violence; and
- strategies, principles, and practices for collecting information about children affected by family and domestic violence.

8.5.7 The Department of Communities has identified that it is developing a family and domestic violence-informed approach that is being developed across its strategic and operational areas

During the investigation, the Office consulted with the Department of Communities about patterns and trends in how the Department identified and responded to family and domestic violence among the children and young women who died by suicide, and was advised that the Department is 'currently undertaking a review of the practice guidance relating to family and domestic violence practice.'[173]

Recently, the Department of Communities has partnered with the Safe & Together Institute to examine the current systemic family and domestic violence responses in Western Australia. In utilising the Safe & Together Institute's Continuum of Domestic Violence Practice, the Department of Communities has highlighted that the 'Department of Communities' competency in responding to family and domestic violence sits across Domestic Violence Destructive, Domestic Violence Neglectful and Domestic Violence Pre-Competent.'[174]

[172] Victorian Government, *Victorian Family Violence Data Collection Framework*, 2020, p. 42-43.
[173] Department of Communities, electronic communication, 29 October 2021.
[174] Department of Communities, 'Family and Domestic Violence-Informed Approach' (PowerPoint presentation), Government of Western Australia, delivered 9 September 2021, Perth, slide 5.

Accordingly, the Department of Communities has highlighted that:

> Communities is developing a Western Australian FDV-Informed Approach that is family violence, trauma and culturally-informed. The development of this approach sits across Strategy and Partnerships, Aboriginal Outcomes and Community Services.
>
> We have partnered with the Safe and Together Institute to start this work:
>
> 1. An organisational assessment of Communities family and domestic violence policies, systems and practices. This is a process that requires staff to audit / review policies, data systems, governance arrangements etc. to examine current family violence capability. It includes a case reading analysis (same methodology as used in the PATRICIA research project) to support detailed analysis of current responses to family and domestic violence (an initial draft has been received by Communities).
>
> 2. Participatory protocol development. Informed by the organisational assessment, Safe and Together Institute will work with Aboriginal staff and Aboriginal stakeholders to develop approaches for working with Aboriginal families.
>
> 3. Implementation of the participatory protocol, and other necessary changes identified through the organisational assessment, to embed good family violence practice in our people, policy and systems.[175]

The Department of Communities has highlighted that work on a family and domestic violence informed approach, and the priority of family and domestic violence responses is congruent across agency projects and ongoing work, including:

- Aboriginal Cultural Framework and Cultural Capability.
- Aboriginal family safety strategy.
- Communities family and domestic violence service model.
- Recommissioning the family and domestic violence sector.
- Developing an integrated family and domestic violence response.
- Senior Officer's Group - Reinvigorated across government commitment.[176]

Recommendation 4: That the Department of Communities consider and incorporate the findings of this investigation when undertaking the development and implementation of a 'Western Australian Family and Domestic Violence-Informed Approach,' regarding:

- the recording of family and domestic violence as a 'primary issue' or 'issue' in ASSIST;
- use of the outcomes 'Not departmental business' or 'Assessed as no further role' when family and domestic violence is identified; and
- the intake of interactions relating to family and domestic violence.

[175] Department of Communities, 'Family and Domestic Violence-Informed Approach' (PowerPoint presentation), Government of Western Australia, delivered 9 September 2021, Perth, slide 6.
[176] Department of Communities, 'Family and Domestic Violence-Informed Approach' (PowerPoint presentation), Government of Western Australia, delivered 9 September 2021, Perth, slide 7.

8.6 Opportunities to improve outreach and engagement with young people and their families

8.6.1 Background

The Ombudsman's 2014 *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (**the 2014 Investigation**) highlighted the experiences of young people who experienced multiple risk factors associated with suicide. This included those recorded as having allegedly experienced one or more forms of child maltreatment, with most also being recorded as having experienced mental health problems and suicidal ideation and behaviour. The 2014 Investigation highlighted research concerning young people at risk, identifying that these young people's involvement with government and non-government agencies was often characterised by perceptions that they were 'difficult:'

> The theme of older adolescent children who were very difficult to help emerged powerfully. Almost all of these 'hard to help' older young people (over the age of 13) had a long history of high level involvement from children's social care and other specialist agencies, including periods of state care.[177]

The 2014 Investigation also highlighted research from the United Kingdom (**UK**) concerning a profile of young people at risk of serious injury or death, which identified that in dealing with adolescents, government and non-government agencies 'appeared to have run out of helping strategies and were sometimes reluctant to assess these young people as mentally ill and/or with suicidal intent:'[178]

> Time was wasted arguing about which agency was responsible for which service and whether thresholds were met, thereby delaying the provision of services that the young people needed. There was a lack of coordination of services for these young people 'in transition' and failures to respond in a sustained way to their extreme distress which occurred in parallel to their very risky behaviour.[179]

In *Preventing suicide by children and young people 2020*, the Office explored these issues further and again 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.

[177] Brandon M, Belderson P, Warren C 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*, 2008, United Kingdom Department for Children, Schools and Families, London, p. 12.
[178] Brandon M, Belderson P, Warren C 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*, 2008, United Kingdom Department for Children, Schools and Families, London, p. 7.
[179] Brandon M, Belderson P, Warren C 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*, 2008, United Kingdom Department for Children, Schools and Families, London, p. 12.

The Office noted research literature identifying that challenging behaviours exhibited by children and young people experiencing cumulative harm are often not understood in the context of trauma and considered interventions introduced in other jurisdictions to better meet the needs of these children, including:

- targeted multi-agency interventions to help meet the needs of older children and young people with complex needs, including those 'who don't quite cross the threshold to be involved in care and protection services, but still have complex needs;'[180]
- interventions for children and adolescents with parents experiencing mental health, drug or alcohol issues;[181] and
- long-term early intervention initiatives introduced to reduce rates of developmentally vulnerable children and young people in areas of socio-economic disadvantage.[182]

The Office also highlighted research literature observing that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help', and agencies face challenges in providing services to these young people.[183] In particular, the Office noted the challenges services face in recognising the non-physical or visual effects of long-term neglect in older children, and that many of the children and young people who died by suicide in Western Australia had been categorised by services as 'resilient', 'risk-taking' and/or 'hard to help':

> 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. …
>
> 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.[184]

[180] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 8-10; 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/>.
[181] 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>.
[182] 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. 2-3.
[183] Brandon M, Belderson P, Warren C 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*, 2008, United Kingdom Department for Children, Schools and Families, London, p. 12.
[184] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 8-10.

Having identified that the interactions about the 13 children and young women known to the Department of Communities (both in total and regarding family and domestic violence) peaked between the ages of 14 to 17 years, but the majority of these interactions did not progress to intake for further action, the Office undertook:

- a comprehensive review of the research literature concerning the drivers of adolescent engagement with service systems, and learnings about the way adolescents are perceived and engaged; and
- an in-depth review and qualitative analysis of the free text details recorded in interactions regarding the 13 children and young women, with particular attention to patterns and trends that emerged when they were older children and adolescents.

8.6.2 The research literature highlights that interventions with adolescents often focus on addressing immediate risks and challenging behaviour, instead of the underlying causes

Recent research in the UK has examined issues that arise in interactions with adolescents, including work by the UK's National Society for the Prevention of Cruelty to Children (**NSPCC**) which has published learnings from 15 case reviews that were published between 2018 and 2019 featuring children and adolescents aged 13 to 18 years. Teenagers in these case reviews 'faced a complex lived experience and wide range of risk factors [and] became the subject of reviews following: suicide or attempted suicide, physical injuries or death at the hands of another person, child sexual abuse and sexual abuse, neglect, and criminal exploitation.'[185] Arising from these reviews, the NSPCC identified a number of key learnings about the manner in which adolescents were perceived and engaged.

The NSPCC identified that 'practitioners sometimes struggle to work with teenagers who are experiencing complex issues [and that] interventions can focus on tackling challenging behaviour, rather than exploring the underlying causes and risk factors:'[186]

> Sometimes professionals labelled a young person's behaviour as "challenging" or "risk-taking", which led to them seeing the behaviour as the problem, rather than identifying what might be causing it, what risks the young person might be exposed to, and what support was needed …
>
> If practitioners perceived that a young person was displaying risk-taking behaviour, for example being involved in criminal activity, this was sometimes seen as a deliberate choice by the child. This perception overshadowed the child's vulnerabilities and the mitigation of any risks they were exposed to. In some instances it led to professionals treating young people as perpetrators of crime and/or anti-social activity, rather than children in need of support.
>
> Practitioners sometimes focused on tackling young people's substance misuse, rather than seeing substance misuse as a possible indicator of abuse and/or exploitation.[187]

[185] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[186] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[187] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 3.

Further research in the UK by Crest Advisory, including a report investigating the drivers of serious violence and trends in violence and patterns of vulnerability among children and young people, identified that 'the way in which adolescents appear or present to adults in authority does not always fit with notions of vulnerability [and that] this may affect how they are treated.'[188] Barriers that practitioners can face in working with adolescents include:

> Cultural issues: we were told that people become social workers because they want to protect 'vulnerable children' (as they imagine them), and now they find themselves working with teenagers who don't fit their image of childhood or vulnerability.
>
> Practical skills: Social workers are trained to recognise family abuse but not necessarily equipped to deal with peer abuse, exploitation or serious violence. They may also feel that they have fewer legal and procedural elvers over the external environments in which significant harm is present – whether that be a local park or school – as they do in family settings.[189]

In consulting with researchers who provide services to adolescents at risk of serious violence, Crest Advisory further identified that 'the young people who are most at risk of involvement in serious violence - teenage boys - are the least likely to be viewed as vulnerable:'[190]

> The reality for lots of these children is that the recording of the journey of vulnerability is too broken … these are children who will have had frequent interactions with social care potentially from birth, school exclusion, multiple primary schools… these records stop and start so often, and are passed between so many people, that a genuine understanding of vulnerability is lost. They are and remain challenging, dysregulated of one mind, of another naughty, bad, not worthy of a place: rejected and moved on.'[191]

[188] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.
[189] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 41.
[190] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.
[191] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.

Text from interactions for the 13 children and young women known to the Department of Communities

Case study 1

The following text is from an interaction regarding a child in care of the CEO:

[Female child, age 13] is engaging in high risk behaviours and is self- selecting her placements which place her an extremely high risk. [Female child, age 13] has self selected her placement … which the Department assessed as being Unsuitable however were supporting given [Female child, age 13's] high risk behaviours.

Case study 2

The following text is from an interaction concerning a sibling of a child in care of the CEO:

[Male child, age 12] is currently choosing to place himself at risk by living on the streets and drug taking. Mother has engaged with [support services] and is attempting, without success at present, to engage [male child, age 12]. [Support services] have been unable to impact on [male child's] inappropriate behaviour however, they …, are trying. It is very likely that [male child, age 12] will be arrested, when located by Police, and it is hoped that his substance abuse and counselling needs can be addressed at this time.

Researchers also identify that those working with adolescents must respond to behaviour and need simultaneously, with a practice paper by the former Queensland Department of Child Safety, Youth and Women identifying that:

> A strong invitation exists for workers to focus their intervention with 'high-risk' adolescents on their challenging, destructive or self-harming behaviour. 'How do we manage this young person's behaviour?' becomes the central question. While workers are aware that high-risk behaviour is an indicator of complex need, acting on this knowledge can take a back seat to efforts to 'contain' and/or prevent the escalation of the behaviour. However, a focus on identifying and addressing needs cannot wait until behaviour is stabilised – work to understand and respond to need must occur simultaneously with acute responses to high-risk behaviour (Joughin & Morley 2007). Indeed, they must be integrated as the same work – even when a paramount need for physical safety is being responded to (for example, acting to prevent a young person harming themselves or others), the way in which this occurs should be informed by assessment of the core emotional needs underpinning the behaviour.[192]

8.6.3 The research literature identifies a need to recognise the vulnerability of young people and not overestimate their maturity or 'resilience'

AIHW notes that 'infants [and] younger children are regarded as the most vulnerable [to being] abused, neglected or otherwise harmed,' and more often receive a response from child protection services:

[192] Queensland Department of Child Safety, Youth and Women, *Practice Paper: A framework for practice with 'high risk' young people (12 – 17 years)*, 2008, Queensland Government, p. 4-5.

> Infants are most likely to receive child protection services Across Australia in 2015–16, infants (children aged under 1) were most likely (37.6 per 1,000 children) to be receiving child protection services and those aged 15–17 were least likely (20.7 per 1,000). The median age of children receiving services was 8 years. These findings reflect that younger children are regarded as the most vulnerable, and most jurisdictions have specific policies and procedures to protect them (AIHW 2017a).[193]

This is further emphasised in research which has 'consistently found that the youngest children are the most vulnerable to abuse- and neglect-related deaths,' and in the work of the Office's Child Death Review function. In identifying patterns and trends in the Child Death Review function from 30 June 2009 to 30 June 2021, the Office's 2020-21 Annual Report highlights that children under one year and children aged one year 'are over-represented compared to the child population as a whole for both investigable and non-investigable deaths.'[194]

However, the Office's 2020-2021 Annual Report likewise identifies that children aged 13 to 17 years are also 'over-represented compared to the child population as a whole for both investigable and non-investigable deaths.'[195] Thirty-three per cent (335) of the 1,002 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2021 related to those aged 13 to 17 years, and 35 per cent of these deaths were investigable.[196] 'Of these children, suicide was the most common circumstance of death, accounting for 45% of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide.'[197]

Researchers highlight the need to counter assumptions about the resilience and independence of teenagers, noting that 'it is easy to fail to recognise or minimise the vulnerability of older children.'[198] In working with adolescents or young people, the former Queensland Department of Child Safety, Youth and Women highlighted that workers 'must subscribe' to some core understandings concerning practice with 'high-risk' young people:

> **Young people are vulnerable**
>
> … It is often assumed that because young people are physically bigger, in contact with people outside their family and 'moving towards independence', they are less vulnerable than younger children. However worker assumptions about the self-care skills, physical robustness, emotional development, resilience and need for independence of adolescents can be misguided and sometimes harmful (Daniel Wassell & Gilligan 2002).
>
> While a young person may be able to disclose abuse or run from an abusive situation before they are badly injured, this does not prevent them from experiencing emotional harm. Nor does it protect them from the threats that can be created by their attempts to protect themselves (for example, the 14 year old girl who ends up on the streets to escape from sexual abuse at home) …

[193] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018*, 2018, Australian Government, Canberra, p. 62-64.
[194] Australian Institute of Family Studies, 'Child deaths from abuse and neglect,' *Child Family Community Australia*, October 2017, viewed 5 December 2021 <https://aifs.gov.au/cfca/publications/child-deaths-abuse-and-neglect>; Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 63.
[195] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 63.
[196] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 80.
[197] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, 2021, p. 63 and 91.
[198] Queensland Department of Child Safety, Youth and Women, *Practice Paper: A framework for practice with 'high risk' young people (12 – 17 years)*, 2008, Queensland Government, p. 1-2.

> Where a young person behaves in ways that are a risk to others (their families, their carers, their peers) the predominant view of them may be the threat they pose to others, rather than their own vulnerability. But young people are children too. A vulnerable young person needs protection, care, to feel loved and a sense of belonging, like any other child. In fact the developmental tasks of adolescence, when combined with the impacts of harm suffered earlier in childhood and current adverse circumstances, make adolescence a very vulnerable time for many young people.[199]

When considering the impacts of family and domestic violence on adolescents, the Victorian Department of Human Services identifies that:

> Adolescents who have experienced family violence are at increased risk of academic failure, dropping out of school, delinquency, eating disorders and substance abuse. They frequently have difficulty trusting adults and often use controlling or manipulative behaviour. Depression and suicidal ideation and/or behaviours are common. Adolescents are also at greater risk of homelessness and of engaging in delinquent and/or violent behaviour.[200]

In reviewing the involvement of vulnerable adolescents and older children with services, UK researchers identified a tendency for practitioners to adopt an approach that affords maturity to adolescents, rather than centring their status as children.

The NSPCC identified that at times, 'practitioners perceived a young person to be independent and mature. This led them to be quick to act in accordance with the young person's expressed wishes, even when it was not necessarily in the young person's best interests.'[201] This, combined with a focus upon the challenging or risk-taking behaviour of adolescents, 'sometimes causes practitioners to lose sight of the fact that teenagers are children in need of protection.[202]

Similarly, expert consultation undertaken by Crest Advisory identified that, rather than meeting the threshold for support (in the cases of criminally-exploited children), there was 'a tendency to view these young people's behaviour, especially in the case of boys, as a sign of criminality, almost a lifestyle choice, rather than evidence of a vulnerable child in need of protection.'[203]

[199] Queensland Department of Child Safety, Youth and Women, *Practice Paper: A framework for practice with 'high risk' young people (12 – 17 years)*, 2008, Queensland Government, p. 1-2.
[200] Department of Human Services, *Assessing children and young people experiencing family violence: A practice guide for family violence practitioners*, 2012, Victorian Government, Melbourne, p. 14.
[201] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 2.
[202] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[203] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.

This was further highlighted in multi-agency work in the UK arising from joint targeted area inspections (**JTAIs**) which has examined how agencies help and protect children. In the JTAI response report entitled 'Growing up neglected: a multi-agency response to older children' (**the JTAI response report**), it was noted that:

> In a small number of cases, children's lack of willingness to engage with professionals was seen as a reason to end social work involvement. In these cases, rationales were given such as children being 'resilient' or that they had 'chosen a lifestyle'. This was a significant concern because those children were left without the support and protection they needed.[204]

This tendency to view the actions of adolescents as arising from the conscious decisions of mature individuals does not align with the reality that 'anyone aged under 18 is legally a child and should be protected as such.'[205] It also does not consider the long-term impacts of abuse, neglect, and trauma,[206] and the way in which these influence the way that some adolescents may engage with services.

In Australia, the Victorian Commission for Children and Young People's 2016 *Neither seen nor heard: Inquiry into issues of family violence in child deaths* also identified that 'young people were allowed to make decisions beyond their capacity,'[207] noting that 'a number of young people were inappropriately left to fend for themselves,' 'despite being poorly equipped to do so.'[208]

[204] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 24.
[205] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 5.
[206] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 3.
[207] Commission for Children and Young People (Victoria), *Neither seen nor heard: Inquiry into issues of family violence in child deaths*, 2016, Victorian Government, p. 40.
[208] Commission for Children and Young People (Victoria), *Neither seen nor heard: Inquiry into issues of family violence in child deaths*, 2016, Victorian Government, p. 34.

Text from interactions for the 13 children and young women known to the Department of Communities

Case study 1

'[Police] attended the home of [female child, age 16] after receiving concerns from some residents of the [complex] about a group of girls aged between 13-16yrs having sex with men from the same units aged 40-50yrs … [in exchange for] with alcohol and drugs ....

When the police attended all the girls were off their faces after sniffing paint. Police spoke to the men who denied the allegations. Police unable to take any action but felt it warranted that they report their concerns to this office due to the girls ages.'

No further action was taken in response to this referral.

Approximately one month later another referral was received from Police and recorded in the following terms:

'Police recently undertook a raid at [female child, age 16's independent living arrangement]. … Drugs, alcohol and stolen property were found at the home. Police are furthering their enquiries regarding numerous vehicle and property thefts associated with those at the home.

Police are aware that DCP have no role due to the children's ages and self selecting their living arrangements, however requested concerns be recorded.'

Case study 2

A referral to the Department of Communities stated that '[female child] is 13 yrs of age and 8 months pregnant.' Referrer stated that they were 'wanting to see what supports you could offer 'female child, age 13].'

Eleven days later the Department of Communities closed a period of 'family support'. The 'approved outcome report' states that the father of the child is a 14 year old male child, and that both children had 'supportive' families who are:

'… working together to look after the little baby and both families had agreed that [female child, age 13 and male child, age 14] need to go back to school when the baby is born.'

8.6.4 The research literature identifies the need to view older children and adolescents' challenging behaviours and unwillingness to engage with services in the context of the long-term impacts of trauma, violence, abuse and neglect

Researchers have identified that in dealing with adolescents, practitioners 'are not always aware of the long-term impact that abuse and neglect experienced in earlier childhood can have on teenagers' mental health and behaviour.'[209]

The JTAI response report identifies that early childhood or chronic trauma 'will most likely affect a child's mental and emotional well-being and behaviour into adolescence and beyond.'[210] Noting that many of the older children reviewed experienced multiple forms of abuse, parental substance abuse, sexual/and or criminal exploitation and serious youth violence, the JTAI response report also identified that 'the impact on those children experiencing trauma was clear to see:'

> They did not have the stability and security of a loving home to provide a safe base from which to explore the outside world and to help them develop the skills to manage transition into adolescence. The impact of trauma for some children included poor decision making, poor judgement and less ability to recognise risk, problems with mental ill health and lack of emotional well-being. Some were constantly alert and anticipating danger so that their behaviour appeared aggressive. For many of these children, the world was a lonely and frightening place. Without a good understanding of the impact of neglect, including the impact of trauma, it is difficult to see how professionals can appropriately support and protect older children.[211]

Research also identifies that adolescent's experiences of trauma can influence their engagement with services, eroding trust in adults, the wider environment, and services offered. This is further compounded when support from services 'often focuses on managing immediate risks rather than building trust:'[212]

> This helps explain why these young people are described as 'hard to reach' or disengaged. They may struggle to manage their emotions. However, anger and non-engagement can often lead to disqualification from support services. To engage may require open minded support from people with the skills, empathy and time to build meaningful relationships with them.[213]

[209] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 3.
[210] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 6.
[211] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 22.
[212] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 50.
[213] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 50.

In working with adolescents, researchers highlight the importance of understanding behaviour in the context of trauma, noting a propensity for interventions to 'focus on tackling challenging behaviour, rather than exploring the underlying causes and risk factors.'[214]

> Practitioners sometimes focussed on the 'young person as the problem' and treated mental health issues at face value, rather than recognising that mental health issues can be an indicator of abuse and neglect… Other factors that can have an impact on young people's wellbeing include parental mental health problems and cycles of children being rejected by and reconciled with their family. Practitioners did not always recognise or know how to respond appropriately to these factors.[215]

This was further examined by the JTAI response report, which found that professionals did not always look at 'the whole child, their history and home circumstances in order to understand presenting behaviours,' sometimes focusing instead on 'the behaviour of the child and lost sight of them as a vulnerable child in need:'

> Decision making then becomes reactive to the child's behaviour or particular events in their life rather than being proactive in tacking the underlying cause.[216]

The Victorian Commission for Children and Young People made similar observations in the report *Lost, not forgotten: Inquiry into children who died by suicide and who were known to Child Protection*, noting:

> … as children grow older and their trauma starts to manifest in challenging behaviour, disengagement from school, risk taking, violence or mental ill health, professionals lose empathy. The children become seen as the problem and referred to as 'difficult', 'needy', 'angry' and 'bad.'[217]

The JTAI response report highlights differences that were observed in service provision to older children and adolescents when professionals had received training on trauma, noting that the impact on frontline work 'was clear to see:'

> In some areas, social workers had received training on the impact of trauma on children and its relationship to neglect. Some youth offending teams have also invested in trauma training in recognition of the relationship between childhood trauma and risk of offending. The impact of this training was clear to see in the work with older children, because their need for therapeutic support to address the impact of neglect including trauma was prioritised. This understanding also supported staff to recognise that it would take time and a skilled approach to build meaningful relationships with children who had been let down or abused by adults for most of their lives. This included giving older children some control over how interventions were planned and delivered.[218]

[214] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[215] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 2-3.
[216] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 12.
[217] Victorian Commissioner for Children and Young People, *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection*, 2019, CCYP, Melbourne, p. 4.
[218] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 6, 22.

Frameworks for trauma informed approaches are also being considered for Australian child protection jurisdictions. The need for creating trauma informed services in the child protection context was highlighted in the Victorian Commission for Children and Young People's *Neither seen nor heard: Inquiry into issues of family violence in child deaths,* which called attention to research identifying:

> Service practices which lead to re-traumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched. In fact research which supports this disturbing claim is growing. Recognition of the reality that '[t]rauma has often occurred in the service context itself' is a major impetus for introduction of 'trauma informed' practice …
>
> Trauma-informed services 'are informed about, and sensitive to, trauma-related issues'. They do not directly treat trauma or the range of symptoms with which its different manifestations are associated. The possibility of trauma in the lives of all clients/patients/consumers is a central organizing principle of trauma-informed care, practice and service-provision. This is irrespective of the service provided, and of whether experience of trauma is known to exist in individual instances.[219]

In noting that 'a trauma informed approach has long been considered good practice in addressing the high prevalence of trauma by people in the service system,' and that 'an unsafe response can escalate and compound trauma, resulting in additional harm,' triggering distress and preventing engagement with support services, the Victorian Department of Health and Human Services has undertaken an extensive consultation process surrounding the development of a Framework for Trauma Informed Practice to 'promote the physical, emotional and cultural safety of people in contact with services for children, young people and families.'[220]

[219] Kezelman C and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery, Adults Surviving Child Abuse,* 2012, cited in Commission for Children and Young People (Victoria), *Neither seen nor heard: Inquiry into issues of family violence in child deaths*, 2016, Victorian Government, p. 62.
[220] Department of Health and Human Services, *Framework for Trauma informed Practice*, 2019, Victorian Government, viewed 19 March 2021 <https://engage.vic.gov.au/framework-trauma-informed-practice>.

Text from interactions for the 13 children and young women known to the Department of Communities

Case study 1

The following text is from an interaction regarding a child in care of the CEO, who was brought into care for reasons relating to neglect, family and domestic violence and parental drug and alcohol misuse. The child was reunified with his mother before returning to foster care due to physical harm perpetrated by his mother:

'[Carer called] … was requesting assistance [with male child, age 8] given his behavioural difficulties today. [Carer] advised that [male child, age 8] had contact with his mother this weekend and since that time he has been disruptive. Today he has been 'especially difficult' [since] this morning [and] he has been 'trashing the place … defiant, aggressive and has been smashing things. … [Carer] is requesting respite for a few hours … [and is] clear that at this time [they do] not feel police intervention is warranted. …'

Approximately two hours after the initial call, the interaction was updated to state that the male child, aged 8, 'has been placed with his mother.'

Approximately four hours from the initial call, within 2 hours of the male child, aged 8 being placed in his mother's care, the interaction was updated again to state that the child's mother called and said that she 'cannot cope with him anymore and … someone needs to pick him up.'

This was recorded in ASSIST as a 'family support' issue and no further action was taken after a file note concerning the above out-of hours contact was provided to the case manager.

Case study 2

In an interaction detailing a referral from WA Police regarding a 13 year old girl, the details recorded state that:

'[Police] advised [female child, age 13] was picked up with a 24 year old male … [female child, age 13] said he was her boyfriend, he said she was his sister and others in the group he was found with said he was an uncle or a cousin. [Female child, age 13] had been drinking however she was not intoxicated but was loud and "mouthy" … [and appeared] well, she was clean, well kept, no visible signs of injuries and her presentation was generally "pretty good".

It was alleged that [female child, age 13] had assaulted the 24 year old male, [and that] this had caused an altercation between the group [which] Police [attended].'

Three days later, the interaction was updated with details indicating that the 13 year old girl's account of her relationship with the older adult male was correct, despite Police's initial dismissal of her account:

'Case Worker contacted carer who stated that] … [female child, age 13] is in a relationship with [a male] who is about 27 years old and they are living together with [the male's] family. Carer said [the 27 year old male] is a full grown man … expressed her disgust [and] … also stated [female child, age 13] is sleeping around with numerous men.

Case Worker searched on ASSIST for [male, aged 27] [and] … discovered [he] … is … believed responsible for …sexual abuse … and should not be placed or have contact with any children.'

8.6.5 The Office identified barriers to effective outreach and engagement with children between the ages of 14 to 17 years from the Department of Communities' interaction notes

The Office's analysis established that the 13 children and young women known to the Department of Communities most frequently came to the attention of the Department when they were between the ages of 14 and 17 years.

In the context of the research literature, and in understanding that infants and younger children are often regarded as most vulnerable to harm, the Office undertook qualitative analysis to identify insights into the nature of issues concerning the adolescents, and the attitudes and decision-making processes of professionals that emerged when engaging with adolescents and these issues.

The Office observed parallels between issues that were identified in the research literature and in the dialogue of duty interactions concerning the 13 children and young women during periods of contact as adolescents, including:

- **perceptions of challenging behaviour**: the research literature identifies that engagement with adolescents sometimes focuses on tackling behaviours, rather than exploring underlying causes and risk factors;[221]
- **affording maturity to adolescents:** researchers identify a tendency for practitioners to adopt an approach that affords maturity to adolescents, rather than centring their status as children. At times this manifested in adolescent's behaviour being perceived as 'a lifestyle choice,'[222] or young people being 'allowed to make decisions beyond their capacity.'[223] In other instances, 'children's lack of willingness to engage with professionals was seen as a reason to end social work involvement';[224] and
- **the long-term impacts of trauma, violence, abuse and neglect:** the research literature identifies that early childhood or chronic trauma 'will most likely affect a child's mental and emotional well-being and behaviour into adolescence and beyond.'[225] Researchers identify that in working with adolescents, there is a propensity for interventions to 'focus on tackling challenging behaviour, rather than exploring the underlying causes and risk factors.'[226]

[221] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.
[222] Crest Advisory, *Violence and vulnerability*, 2020, London, p. 49.
[223] Commission for Children and Young People (Victoria), *Neither seen nor heard: Inquiry into issues of family violence in child deaths*, 2016, Victorian Government, p. 40.
[224] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 24.
[225] Her Majesty's Government, *Growing up neglected: a multi-agency response to older children*, 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation, p. 6.
[226] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 1.

Underpinning these issues, researchers have identified that a tendency to view the actions of adolescents as arising from the conscious decisions of mature individuals does not align with the reality that 'anyone aged under 18 is legally a child and should be protected as such.'[227] In Western Australia, the provisions of the *Children and Community Services Act 2004* relate to children, defined by section 3 of the Act as 'a person who is under 18 years of age.'

8.6.6 There is ongoing work on the Department's *At Risk Youth Strategy*

The former Department for Child Protection and Family Support's *At Risk Youth Strategy 2015-2018:*

> … sits within the context of the [Department of Communities] lead role in creating safety for young people at risk. The Department shares this responsibility with other government agencies, community services sector organisations and the broader community.[228]

The *At Risk Youth Strategy 2015-2018* identifies that 'young people who are identified as being "at risk" due to a variety of behavioural, situational and educational factors are at the focus' of the strategy, and that:

> The Department has a role with these at risk young people including those who are in the care of the Chief Executive Officer (CEO). The Department will provide protection and care to a young person in cases where existing support is insufficient to create safety and promote the wellbeing of that young person within their family.
>
> The Strategy has been developed to guide the Department's ongoing role in planning and delivering services that support and encourage young people to reach their potential and promote safety in the community.[229]

The Office sought further information from the Department of Communities about the development of a new at-risk youth strategy for 2019 and beyond and was advised that 'there is ongoing work occurring between Communities and Minister McGurk's Office to review and finalise this strategy.'[230]

[227] National Society for the Prevention of Cruelty to Children, *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers*, 2021, NSPCC Learning, London, p. 5.
[228] Department for Child Protection and Family Support, *At Risk Youth Strategy 2015-2018*, 2015, Government of Western Australia, Perth, p. 5.
[229] Department for Child Protection and Family Support, *At Risk Youth Strategy 2015-2018*, 2015, Government of Western Australia, Perth, p. 4.
[230] Department of Communities, electronic communication, 29 October 2021.

The Office notes that significant work has also been undertaken with at-risk young people in Western Australia under the Department of Communities' *Earlier Intervention and Family Support Strategy*, since 2016, which seeks to 'effectively meet the needs of vulnerable families and young people' by working together 'with other government and community sector agencies … [to provide] Earlier, intensive intervention with high risk families before problems become entrenched'.[231] Ultimately, the goal of the *Earlier Intervention and Family Support Strategy* is to 'achieve better outcomes for families with complex and multiple needs and to prevent children from needing out-of-home care wherever possible.'[232]

Services have additionally been provided to at-risk youth in Western Australia as part of the Department of Justice's 'Target 120' program since 2018-19, which aims to reduce juvenile reoffending by 'bringing across-government resources together to support young people at risk of becoming prolific offenders, and their families, on a voluntary basis.'[233]

Recommendation 5: The Department of Communities, in order to better inform practice and policy, conducts a review and examines current data on:

- the presence of family and domestic violence in duty interactions concerning older children and adolescents;
- intake rates related to duty interactions concerning older children and adolescents, particularly where family and domestic violence is identified;
- policy, practice, and culture in relation to how the Department of Communities responds to older children and adolescents; and

provides the resulting review report to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this Investigation.

[231] Department of Communities, *Casework Practice Manual: Overview – At risk youth*, 4 April 2022, <https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=273>; Department of Communities, *Casework Practice Manual: Overview – Family support and earlier intervention*, 28 June 2018 <https://manuals.communities.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=274>.
[232] Department for Child Protection and Family Support, *Building Safe and Stromg Families: Earlier Intervention and Family Support Strategy*, September 2016, Government of Western Australia, p. 5.
[233] Department of Communities, *Target 120 Evaluation Progress Report*, March 2020, p. 3.

Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	October 2022
A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee	September 2022
A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020	September 2021
An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	July 2021
Preventing suicide by children and young people 2020	September 2020
A report on giving effect to the recommendations arising from 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

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Investigation into family and domestic violence and suicide

Volume 4: The need for trauma informed responses

Ombudsman Western Australia

About this Report

This report is available in print and electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with disability. Requests should be directed to the Publications Manager.

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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 emerging.

CONTENT WARNING

This report contains information about suicide, family and domestic violence 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 women and children who died by suicide.

The Institution of the Ombudsman

The institution of the Ombudsman is more than 200 years old. The institution of the Ombudsman promotes and protects human rights, good governance and the rule of law as recognised through the adoption in December 2020 by the United Nations General Assembly of Resolution 75/186, *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*.

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Ombudsman Western Australia

Ombudsman Western Australia is one of the oldest Ombudsman institutions in the world. The Ombudsman is an independent and impartial officer who reports directly to Parliament. The Ombudsman receives, investigates and resolves complaints about State Government agencies, local governments and universities, undertakes own motion investigations, reviews child deaths, reviews family and domestic violence fatalities and undertakes inspection, monitoring and other functions.

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The office of the Western Australian Ombudsman takes pride in diversity and equal opportunity. The office stands with the LGBQTIA+ community. The Ombudsman's pronouns are he/him/his.

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Ombudsman Western Australia acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of this land. We recognise and respect the 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 emerging.

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Getting help and finding support

If a life is in danger, or someone you know is at immediate risk of harm, call 000.

If you, or someone you are with is highly distressed, feeling unsafe and thinks they are a risk to themselves, go to your nearest emergency department.

If you are worried about a person who refuses to go to an emergency department, and need urgent mental health assistance, please contact:

Mental Health Emergency Response Line: 1300 55 788 (Perth) or 1800 676 822 (Peel)

rapid response for after-hours mental health emergencies in the Perth and Peel metro areas, or connection to your local mental health service during business hours

Rurallink: 1800 552 003 (regional Western Australia, free call)

specialist after hours mental health telephone service for people in rural communities, 4.30 pm to 8.30 am, Monday to Friday and 24 hours Saturday, Sunday and public holidays, and for connection to your local mental health service during business hours

Suicide Call Back Service: 1300 659 467 or suicidecallbackservice.org.au

free phone, video and online counselling for people at risk of suicide, concerned about someone at risk, bereaved by suicide and people experiencing emotional or mental health issues

Child and Adolescent Mental Health Service Crisis Connect: 1800 048 636

phone and online videocall support for children and young people experiencing a mental health crisis as well as support and advice to families and cares, available seven days a week from 8.30 am to 2.30 pm across the Perth metro area

Australia-wide 24 hour mental health support lines

Lifeline: 13 11 14 or lifeline.org.au

24 hour telephone crisis support and suicide prevention online crisis support chat available from 7 pm to midnight AEST

13 YARN 13 92 76

the first national crisis support line for mob who are feeling overwhelmed or having difficulty coping, they offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal & Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week

Beyond Blue: 1300 22 4636 or beyondblue.org.au

immediate support available 7 days a week, through phone (24 hours), online chat (3 pm to 12 am) or email (response within 24 hours)

1800RESPECT: 1800 737 732 or 1800respect.org.au

24 hour phone and web chat counselling for people impacted by sexual assault, domestic or family violence and abuse

MensLine Australia: 1300 78 99 78 or mensline.org.au

phone, video and web counselling for men who want to take responsibility for their violence and have healthy and respectful relationships

StandBy Support After Suicide: 1300 72 77 47

a program focused on supporting anyone who has been bereaved or impacted by suicide at any stage in their life

Additional support services

Women's Domestic Violence Helpline: 1800 007 339

provides support for women, with or without children, who are experiencing family and domestic violence in Western Australia (including referrals to women's refuges)

Men's Domestic Violence Helpline: 1800 000 599

provides telephone information and referrals for men in Western Australia who are concerned about their violent and abusive behaviours

Crisis Care: 9223 1111 or 1800 199 008

provides Western Australia's after-hours response to reported concerns for a child's safety and wellbeing and information and referrals for people experiencing crisis

Sexual Assault Resource Centre: (08) 6458 1828 or freecall 1800 199 888

provides a range of free services to people affected by sexual violence

Derbarl Yerrigan Health Service: 9241 3888 or dhys.org.au

health and medical support for Aboriginal people, including counselling, Mon-Fri 9 am to 5 pm

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

phone, web chat or email counselling support for people affected by complex mental health issues, available from 10 am to 10 pm AEST

GriefLine: 1300 845 745 (landlines) or (03) 9935 7400 (mobiles) or griefline.org.au

free phone counselling and support for people experiencing grief, loss and trauma, 6 am to midnight AEST, seven days a week

Active Response Bereavement Outreach (ARBOR): 1300 11 44 46 or arbor.bereavement@anglicarewa.org.au

a free service offering short-medium term grief counselling, practical & emotional support, appropriate referral support, volunteer lived-experience peer support, and support groups to people recently impacted by losing loved ones to suicide

QLife: 1800 184 527 or qlife.org.au

3 pm to midnight, 7 days per week, telephone and webchat counselling for LGBTI people

Support services for children and young people

Kids Helpline: 1800 55 1800 or kidshelpline.com.au

24 hour telephone and web chat support for kids, teens and young adults from 5 to 25 years and their parents, carers, teachers, and schools

headspace: headspace.org.au/eheadspace

free telephone and online support and counselling for children and young people 12 to 25 years, their families and friends

Children and Young People Responsive Suicide Support (CYPRESS): 1300 11 44 46 or info@anglicarewa.org.au

support service for children and young people between the ages of 6 and 18 who have been bereaved by suicide

Translating and interpreting

If you are assisting someone who does not speak English, first call the Translating and Interpreting Service (**TIS**) on 13 14 50 and they can connect you with the service of your choice and interpret for you.

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1 Overview

Volume 1 of the investigation report, *Executive Summary*, outlines the role of the Ombudsman, the objectives and methodology of the investigation and a summary of the findings and recommendations.

Volume 2 of the investigation report, *Understanding the impact of family and domestic violence and suicide*, outlines the reasons why family and domestic violence increases the risk of suicide and self-harm in women and children, as identified in the research literature. It also explores what family and domestic violence looks like and feels like for victims and presents important context about family and domestic violence and suicide in Western Australia, including:

- definitions of family and domestic violence;
- coercive controlling behaviour;
- research examining the nature of family violence among Aboriginal and/or Torres Strait Islander people, families and communities; and
- research examining the impact of family and domestic violence upon children and adolescents.

Volume 3 of the investigation report, *Contact between victims of family and domestic violence who died by suicide and State government departments and authorities* details the Office's consideration of the deaths of 68 Western Australian women and children who were victims of family and domestic violence and died by suicide during the investigation period, and:

- includes an overview of state-wide WA Police data relating to family and domestic incidents between 1 January and 31 December 2017 (the investigation period);
- sets out how family and domestic violence is identified in the records of the WA Police Force, courts hearing restraining order proceedings, corrective services, hospitals and child protection services in Western Australia;
- details the instances where records show that the 68 women and children who died by suicide had experienced repeat or persistent violence;
- sets out patterns of contact, including the time between the victim's most recent contact with each agency prior to their death; and
- explores differences in the patterns and trends between the 68 women and children State government departments and authorities.

This volume of the investigation report, *Volume 4: The need for trauma informed responses*, identifies the current systemic responses to family and domestic violence provided by State government departments and authorities. It explores the need for agencies to continuously improve their focus on achieving safety for women and children and provide trauma informed services to better meet their needs.

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2 The Ombudsman's Child Death Review function

The Child Death Review function enables the Ombudsman to review investigable deaths. Investigable deaths are defined in section 19A(3) of the Ombudsman's legislation, the *Parliamentary Commissioner Act 1971,* and occur when a child dies in any of the following circumstances:

- In the two years before the date of the child's death:
    - The Chief Executive Officer (CEO) of the Department of Communities (Communities) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 200*4, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and
    - Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.

- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

The Ombudsman commenced the Child Death Review function on 30 June 2009.

In the Ombudsman's 2020-21 Annual Report, analysis highlighted a number of social and environmental factors that were associated with investigable child deaths. Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

The Office identified that family and domestic violence was identified in almost three quarters (74 per cent) of investigable child death reviews for the period 30 June 2009 to 30 June 2021. The following observations were also made:

- Where family and domestic violence was present:
    - parenting was a co-existing factor in nearly two-thirds of the cases;
    - alcohol use was a co-existing factor in over half of the cases;
    - drug or substance use was a co-existing factor in over half of the cases;
    - homelessness was a co-existing factor in over a quarter of the cases; and
    - parental mental health issues were a co-existing factor in over a third of the cases.[1]

[1] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, OWA, Perth, 2021, p. 70.

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3 The Ombudsman's Family and Domestic Violence Fatality Reviews

Following a State government working group process examining models for a family and domestic violence fatality review process, the (then) State government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function.

On 1 July 2012, the Office commenced its Family and Domestic Violence fatality review function. In the Ombudsman's 2020-21 Annual Report, analysis highlighted that:

> In 44 (61%) of the 72 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 13 (33%) of the 40 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.[2]

3.1 Previous own motion investigations

Following the establishment of the Ombudsman's Child Death Review and Family and Domestic Violence Fatality Review functions, the Office has undertaken a number of own motion investigations relating to suicide by children and young people and family and domestic violence fatalities.

The work of the Office in undertaking own motion investigations has consistently highlighted experiences of violence, abuse, and trauma in the lives of individuals who have gone on to die by suicide, and in the lives of individuals who have been killed as a result of family and domestic violence. This work has also highlighted the significant patterns of contact that many individuals affected by violence, abuse, and trauma had with State government departments and authorities prior to their deaths.

3.1.1 *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (the 2014 Investigation)

As part of the 2014 Investigation, the Office examined the deaths of 36 young people who died by suicide. The Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced.

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

- all of these 20 young people allegedly experienced some form of child maltreatment including family and domestic violence, sexual abuse, physical abuse or neglect;
- 19 of these young people were recorded as having allegedly experienced child maltreatment in conjunction with other factors associated with suicide; and

[2] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, OWA, Perth, 2021, p. 133.

- as a group, these 20 young people had extensive contact with State government departments and authorities.[3]

The 2014 Investigation identified that 17 of the 20 young people in Group 1 were recorded as having allegedly experienced more than one form of child maltreatment and were therefore likely to have suffered cumulative harm. The Office highlighted research literature identifying that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments to recognise cumulative harm. Accordingly, the 2014 Investigation made the following recommendation:

> Recommendation 9: The [then] Department for Child Protection and Family Support considers whether an amendment to the Children and Community Services Act 2004 should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.[4]

3.1.2 *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* (the 2020 Investigation)

In addition to the 36 deaths by children and young people examined in the 2014 Investigation, the 2020 Investigation examined records relating to an additional 79 children and young people who died by suicide following the 2014 Investigation. Collectively, these young people are referred to as the 115 children and young people.

The 2020 Investigation 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; and
- 64 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, mental health issues, substance and adverse family experiences.[5]

The 2020 Investigation highlighted that 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. Accordingly, the 2020 Investigation made the following recommendation:

[3] Ombudsman Western Australia, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, 2014, p. 67-74.
[4] Ombudsman Western Australia, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, 2014, p. 116-122.
[5] Ombudsman Western Australia, *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*, 2020, p. 181.

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.[6]

3.1.3 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* (the 2015 Investigation)

As part of the 2015 Investigation, the Office examined the fatalities of 30 people who were killed where the relationship between the person who was killed and the suspected perpetrator was a family and domestic relationship. The Office's further analysis of these 30 fatalities identified that, for 24 individuals (80 per cent), there was a prior recorded history of family and domestic violence:

- for 16 of these individuals, there was a recorded prior history of family and domestic violence involving the person who was killed and the suspected perpetrator;
- for eight of the fatalities, there was a recorded prior history of family and domestic violence involving either the person who was killed and a third party, or the suspected perpetrator and a third party; and
- the Office also identified that, in 17 of the 30 fatalities (57 per cent), Violence Restraining Orders involving at least one of the people involved in the fatality were granted at some point in time.

The 2015 Investigation made 54 recommendations to State government departments and authorities. These recommendations related to victims, perpetrators, and children affected by family and domestic violence, and strategic planning and responses to Aboriginal family violence.

[6] Ombudsman Western Australia, *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*, OWA, Perth, 2020, p. 236.

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4 Patterns and trends in victims' contact with State government departments and authorities prior to their death

4.1 Victims of family and domestic violence who died by suicide had significant contact with State government departments and authorities

In Volume 3, the Office analysed patterns of contact between the 68 women and children victims of family and domestic violence who died by suicide and State government departments and authorities, including:

- family and domestic violence related contact with the WA Police Force; and
- contact with health, corrective services and child protection services.

The Office identified that many of the 68 women and children had high levels of contact with State government departments and authorities.

This finding aligns with findings of the Queensland Domestic and Family Violence Death Review and Advisory Board, which highlights that 'in comparison with the service system contact recorded for domestic and family violence related homicides, cases that ended in a suicide death had greater contact with a range of services, suggest[ing] that there could be greater opportunities to intervene to help prevent these deaths.'[7]

4.1.1 Patterns in contact among the 68 women and children demonstrate significant demand for crisis services in the absence of available longer-term support

Western Australia's *Aboriginal Empowerment Strategy* identifies that 'government services generally fall into three basic categories, based on how intensive, urgent or reactive they are. Different sectors use different terminology for these categories (and different numbers of categories), however the table below shows the key basic characteristics:'[8]

[7] Queensland Domestic and Family Violence Death Review and Advisory Board, *2018-2019 Annual Report*, 2019, p. 40.
[8] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 32.

Table 1: Types of Government Services, as identified in Western Australia's Aboriginal Empowerment Strategy

Primary Preventative Universal Resilience	Secondary Restorative / Early intervention Targeted Stabilisation	Tertiary Reactive Mandatory / Statutory Crisis
Support wellbeing, foundational needs and capacities, inclusion, and protective factors, before issues arise	Reduce vulnerability and the risk factors leading to the need for crisis response	Provide safety and protection of self or others from identified risk
EXAMPLES • Parenting and early years • Youth recreation • Cultural programs and healing • Education and skills • Community infrastructure • Public health initiatives • Safe and stable housing	EXAMPLES • Youth Diversion • Youth diversion programs • Tenancy supports • Financial counselling • Rehabilitation facilities • Family counselling	EXAMPLES • Prisons • Hospitals • Children in out-of-home care • Women's refuges

Source: Aboriginal Empowerment Strategy[9]

In this context, the Aboriginal Empowerment Strategy identifies that prisons, hospitals, children in out-of-home care, and women's refuges are examples of tertiary, reactive, or crisis responses:

> These services are more cost-intensive, depend more on involuntary or coercive engagement, and involve higher risks. If current trends continue, demand for these "downstream" services is set to increase significantly in coming years.[10]

4.1.2 The underlying drivers of demand for crisis-oriented service provision are also inherently related to suicide prevention

Key Western Australian inquiries and strategic frameworks have highlighted the need to address the underlying drivers of demand upon crisis responses, including in the context of suicide prevention.

In the State Coroner's 2017 *Inquest into the deaths of 13 children and young persons in the Kimberley*, the Coroner elevated the voices of key stakeholders in the Kimberley. In identifying 'proximal causes' that 'trigger a suicide or suicidal attempt,' including 'alcohol and other drug use/misuse, relationship difficulties and/or family conflict/violence,' stakeholders identified that these factors are underpinned by issues such as 'historical trauma, racism, economic disadvantage and cultural breakdown rather than mental illness or alcohol abuse. The Coroner also identified other contributing factors such as family relationships, poor living conditions, boredom and hopelessness, highlighting a paper by the Kimberley Aboriginal Health Planning Forum which concluded that:'

> Suicide and self-harm are tragic symptoms not of mental illness, but of underlying inter-related social/historical/political factors which are not modifiable by the mental health interventions currently available in the Kimberley. To prevent

[9] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 32.
[10] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 33.

> further suicides a broad response which builds resilience and addresses causal factors, and is designed and implemented by local Aboriginal people, has to be the way forward. In addition, it should be noted that it would be unproductive to consider suicide in isolation from other related issues such as child sexual abuse, alcohol abuse/other addictive behaviours, jealousing, family/domestic violence and incarceration in prison. All these issues have vastly elevated rates across the Kimberley, and this is no coincidence. They each share very similar or identical causes and feed into each other in a relentless and perpetual cycle.[11]

The importance of addressing the underlying drivers demand upon crisis services has also been highlighted by Western Australia's Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 in Western Australia (**the Ministerial Taskforce**). The Ministerial Taskforce was established in early 2021 following the Chief Psychiatrist's review into the care of Kate Savage, a 13-year-old who tragically died while under the care of the Child and Adolescent Health Service.

In examining mental health related service provision to Western Australian infants, children, and adolescents, Ministerial Taskforce Chair Robyn Kruk AO set out 10 overarching and emerging directions that Taskforce believe are critical in securing better mental health outcomes for children and strengthening support for families, including to:

> Recognise the importance of providing appropriate interventions early in a child's life rather than allowing crisis situations to escalate.[12]

In reviewing the apparent suicides of Aboriginal and/or Torres Strait Islander adolescents, Queensland's Death Review and Advisory Board has also highlighted that high levels of service system contact were reactive to key issues in adolescents' lives:

> There was a high level of service system contact within the cases. … the service response was symptomatic and there was a distinct lack of early intervention or support programs to address underlying trauma in the young person's life or to provide any services in a culturally safe way.[13]

Western Australia's Aboriginal Empowerment Strategy notes that 'preventative and early intervention initiatives can bring about positive changes that reduce the need for crisis responses. Initiatives in this category proactively build up resilience, capability, healing, and independence – in short, self-determination.'[14] Accordingly, a key element of the Aboriginal Empowerment Strategy therefore requires the State government to invest 'in building strengths, prevention and earlier intervention' and:

i) Invest in initiatives that build strengths, reduce vulnerability through prevention and early intervention, and minimise the later need for crisis responses; and

ii) Improve the integration of services. [15]

[11] *Inquest into the deaths of 13 children and young persons in the Kimberley* (Coroner's Court of Western Australia, Coroner RVC Fogliani, 7 February 2019) 33.
[12] Ministerial Taskforce into Public Mental Health Services for Infants, Children, and Adolescents aged 0-18 in Western Australia, *Emerging Directions: The Crucial Issues For Change*, 2021, p. 6.
[13] Queensland Domestic and Family Violence Death Review and Advisory Board, *2018-2019 Annual Report*, 2019, p. 9.
[14] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 33.
[15] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 33.

4.2 The research literature consistently identifies that victims of family and domestic violence act to resist violence perpetrated against them and protect their children

The research literature identifies that victims of family and domestic violence use a wide array of strategies to resist violence, and that the way in which victims respond to and resist violence depends upon the dangers and opportunities of their specific circumstances.[16]

Victims may resist violence utilising covert and overt strategies.[17] Overt resistance strategies used by victims can include openly challenging the perpetrator's behaviour; 'accessing formal and/or informal help' and/or separating from the perpetrator, which can involve 'a range of autonomous behaviors that directly challenge [sic]' a partner's control.[18] Covert resistance involves taking action without the perpetrator knowing about it, such as 'storing away personal objects or thinking about something else during an abusive incident.'[19] In this context, the research literature observes that 'victims are acutely aware that any defiant acts will be matched by an increase in the perpetrator's violence,' and that 'agency and service records serve as a testament that victims' acts of resistance are generally overlooked and unrecognised.[20]

Family and domestic violence researchers also identify that some protective strategies employed by victims may create the perception that a victim is also a perpetrator of violence or not responding in a way that may align with expectations, such as 'fighting back or defying the [perpetrator],' or using or abusing substances as an 'escape' or to numb physical pain.[21]

> Although these protective strategies act as coping and survival mechanisms for victims, they are frequently misinterpreted by laypersons and professionals who view the victim's behavior as uncooperative, ineffective, or neglectful.[22]

Researchers identify that for some victims use of force is 'not always defensive … often it is more aptly described as "violent resistance"', through which some women respond to a violent partner with violence to stop or reduce the violence, or in 'anger, frustration or retaliation.'[23] In resisting and responding to violence with the use of force, or in demonstrating behaviour that is likely to 'challenge our culture's dominant 'real' victim stereotype,' the actions of some victims are not seen in the context of broader violence:

> Significantly … victims of family violence might engage in defensive or retaliatory behaviours as a response to violence. Where police use an incident-specific lens

[16] For example, Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, p. 28
[17] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 3.
[18] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 5.
[19] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 3.
[20] Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, p. 27-28.
[21] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 28.
[22] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 29.
[23] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.

> and do not see the context of the violence, this may erode the legitimacy of a woman's [or victim's] 'victimhood'.[24]

Researchers identify that these factors influence police decision making.[25] In 2010, the Australian Law Reform Commission observed that, if police 'fail to identify the "primary aggressor" and the "primary victim" when attending a scene of family violence,' 'this may mean that victims are wrongly charged with family-violence related offences and inappropriately having protection orders taken out against them.'[26] A Western Australian stakeholder observed that:

> The view put forward by the Western Australia Police is that, although understanding the nature of domestic violence is crucial to ensuring an effective response, ultimately members are only able to respond to the circumstances before them. In ambiguous circumstances, an understanding of who is likely to be the primary aggressor will be a useful guide. However, if the female is the one who clearly appears to be threatening to commit an act of family and domestic violence, the police are obliged to respond to the circumstance before them. According to police, this means that, just as it is not the role of police to take into consideration circumstances that may amount to a defence when considering whether to arrest for the commission of an offence, police are obliged to issue an order against the woman notwithstanding that she may have been subjected to acts of domestic violence many times in the past.[27]

The research literature consistently identifies that victims of family and domestic violence act to resist violence perpetrated against them and to protect themselves and their children, and/or seek help.[28] At times, victims' decisions about how they resist violence and attempt to protect themselves do not align with the expectations of outsiders or State government departments and authorities. This does not negate their experiences as victims of family and domestic violence, and does not mean that victims do not need, want, or are less deserving of help.

4.3 Perpetrators seek to avoid accountability for their violence and may manipulate institutions to maintain power and control over their victims

The research literature suggests that perpetrators of family and domestic violence will take steps to avoid being held accountable for their behaviour, including instances where perpetrators may present the violence as mutual or joint, both to avoid responsibility and to

[24] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 4.
[25] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[26] Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[27] Centacare Safer Families Support Service, quoted by Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2020, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[28] For example, Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington.

shift responsibility to the victim.[29] This includes where perpetrators describe violence as an 'argument' or 'retaliation' or allege that a victim is an unfit or incapable parent.[30]

Examples of strategies used by perpetrators to manipulate institutions and maintain control over a victim include:

- Threatening to call Child Protective Services … and making actual reports that his partner neglects or abuses the children.
- Changing lawyers and delaying court hearings to increase his partner's financial hardship.
- Telling police officers she hit him, too.
- Giving false information about the criminal justice system to confuse his partner or prevent her from acting on her own behalf.[31]

The Department of Communities identifies that collusive child protection practice entails significant risk of endangering women and children's safety, observing that:

> Men who perpetrate violence can be persuasive and subtle in the ways they downplay, deny, justify and rationalise their behaviour. Furthermore, they hold implicit beliefs—about women, relating to women and relationships—that enable them to feel right and vindicated regarding their behaviours and to perceive themselves as the victim in their interpersonal relationships.
>
> When you are trying to engage a perpetrator of family and domestic violence, it is very likely that he will try to get you to collude with his narrative about the violence, perhaps by:
>
> - presenting as calm, collected and reasonable;
> - presenting his (ex)partner as irrational, unreasonable or mentally ill;
> - lying about or omitting known facts, or presenting a partial picture;
> - claiming his partner is lying or fabricating evidence;
> - claiming 'the system' is out to get him;
> - speaking on behalf of his (ex)partner—especially if he is her carer;
> - claiming the violence is mutual;
> - acknowledging some wrongs while not accepting responsibility; or
> - attempting to use humour or other forms of charm to win you over.
>
> … If you collude, you might reinforce the perpetrator's violence-supporting narratives, at considerable cost to his family members.[32]

As identified in the Ombudsman's 2015 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, it is critically important that all State government departments and authorities working with women and child victims of family and domestic violence are aware of the risk of being manipulated by perpetrators.

[29] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, Perth, p. 12.
[30] Chung D, Green D, Smith G et al, *Breaching Safety: Improving the Effectiveness of Violence Restraining Orders for Victims of Family and Domestic Violence*, 2014, The Women's Council for Domestic and Family Violence Services, Perth, p. 11.
[31] Alabama Coalition Against Domestic Violence, *Why do Abusers Batter?*, Alabama Coalition Against Domestic Violence, cited by Ombudsman Western Australia *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, 2015, p. 129.
[32] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, Perth, p. 47-48.

5 Providing effective service responses to family and domestic violence and suicide

5.1 We know enough to begin incorporating understandings of the association between family and domestic violence and suicide into service responses

The Office notes that systematic reviews and the work of other Australian jurisdictions has demonstrated a significant association between family and domestic violence and suicide.[33] As one expert examining the connection between suicide among females and children experiencing family and domestic violence succinctly stated: 'We know enough to know we should be seriously concerned about this.'[34]

In Queensland, the Domestic and Family Violence Death Review and Advisory Board has reported that 'apparent suicides contribute the largest number of domestic and family violence deaths each year in Queensland.'[35] Highlighting 'the apparent correlation between domestic violence perpetration and suicide,' in 2017 the Queensland Domestic and Family Violence Death Review and Advisory Board identified that 'a more responsive service system which identifies and manages this elevated risk is needed:'[36]

> However, the Board recognised that while a heavy onus is often placed on front-line practitioners to manage these types of issues, a broader response which aims to provide the systems, structure and practice framework for staff, is required to ensure that more meaningful support is provided over the longer term.[37]

While cognisant of the research literature's questioning of this association and in acknowledgement of some of the limitations of this work arising from 'the degree of variability in the focus and methods employed,' the Office has also identified instances in other Australian jurisdictions where knowledge about the association between family and domestic violence and suicide has been incorporated into relevant strategies and frameworks.[38]

5.2 Proposals to criminalise coercive control

Increasingly, Australian researchers, advocates and professionals working in the field of family and domestic violence have called for legislative change to criminalise coercive control.[39] These calls were bolstered following the February 2020 murders of Queensland woman Hannah Clarke and her three young children, Aaliyah, Laianah, and Trey. Following

[33] MacIsaac M, Bugeja L and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61.
[34] Prof. Vanessa Munro, quoted by Moore, A. 'Fatal truth: how the suicide of Alex Reid exposed the hidden death toll of domestic violence,' *The Guardian*, 24 March 2021, viewed 10 May 2021 <https://www.theguardian.com/society/2021/mar/24/fatal-truth-how-the-suicide-of-alex-reid-exposed-the-hidden-death-toll-of-domestic-violence>.
[35] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 25.
[36] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 15.
[37] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 15.
[38] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, 32(8), p. 678.
[39] Bilston G, Cehtel Y, Chilcott B et al, 'Coercive control is a form of intimate terrorism and must be criminalised,' *The Guardian*, 6 October 2020, viewed 12 October 2020 <https://www.theguardian.com/commentisfree/2020/oct/06/coercive-control-is-a-form-of-intimate-terrorism-and-must-be-criminalised>.

their deaths, the Queensland Women's Safety and Justice Taskforce 'conducted a wide-ranging review into the experience of domestic and sexual violence victims in Queensland's criminal justice system,' with the report of this review, released in December 2021, subsequently recommending a staged approach to criminalising coercive control in Queensland.[40]

Also in December 2021, in response to recommendations from its Joint Select Committee on Coercive Control, the New South Wales government 'committed to outlawing coercive control in current and former intimate partner relationships.'[41]

Scotland has recently criminalised coercive control, with the *Domestic Abuse (Scotland) Act 2018* being described as 'a new gold standard.'[42] Although the law has only recently come into operation, with 'women's experiences when reporting under the law [varying] from place to place,' researchers have identified that the laws 'are encouraging victims to come forward and report these crimes.'[43] The laws have also 'enabled authorities to punish behaviour with significant jail time that would otherwise have been difficult to prosecute.'[44]

There is ongoing debate surrounding the criminalisation of coercive control in Australia. Some researchers highlight the need for caution when considering the criminalisation of coercive control, noting that successful law reform would 'rely on victims' willingness and ability to involve police,' and police officers being equipped 'to identify the coercive and controlling behaviours,' and the key issue of 'how to prove coercion:'[45]

> Some of these critics are concerned that women could mistakenly be identified as primary aggressors if police aren't properly trained…
>
> Critics are also concerned that a new law could divert vital resources away from domestic violence prevention. They also worry that the male-centric and adversarial nature of the criminal justice system might make it an inappropriate forum to address an issue that overwhelmingly affects women.[46]

Proponents have highlighted that these issues, and concerns 'about the ability of the justice system to protect women … are not issues that are specific to a coercive control offense,'[47] arguing:

> When done right, the introduction of this new offence includes extensive consultation with the domestic and family violence sector; an iterative drafting process that acknowledges the local context in which the offence will operate; and an extensive lead-in period during which everyone – police, prosecutors, the

[40] Gramenz E, 'Task force recommends stages approach to criminalising coercive control in Queensland,' *ABC News*, 2 December 2021, viewed 12 December 2021 <https://www.abc.net.au/news/2021-12-02/queensland-report-coercive-control-released/100668654>.
[41] New South Wales Government, 'Government to criminalise coercive control,' *Media Releases,* 18 December 2021, viewed 19 December 2021 <https://dcj.nsw.gov.au/news-and-media/media-releases/2021/government-to-criminalise-coercive-control.html>.
[42] Brooks L, 'Scotland set to pass 'gold standard' domestic abuse law', *The Guardian*, 1 February 2018, viewed 15 October 2020, <https://www.theguardian.com/society/2018/feb/01/scotland-set-to-pass-gold-standard-domestic-abuse-law>.
[43] Yousaf H, quoted in 'New domestic abuse laws: More than 400 crimes recorded,' *BBC News*, 17 August 2019, viewed 15 October 2020 <https://www.bbc.com/news/uk-scotland-49374667>.
[44] Gearing A, 'Coercive control and domestic abuse: what might have saved Hannah Clarke and her children?', *The Guardian*, 29 February 2020, viewed 15 October 2020 <https://www.theguardian.com/society/2020/feb/29/coercive-control-and-domestic-abuse-what-might-have-saved-hannah-clarke-and-her-children>.
[45] Fitz-Gibbon K, Walklate S and Meyer S, 'Australia is not ready to criminalise coercive control – here's why,' *The Conversation*, 1 October 2020, viewed 12 October 2020 <https://theconversation.com/australia-is-not-ready-to-criminalise-coercive-control-heres-why-146929>.
[46] McGorrery P and McMahon M, 'It's time 'coercive control' was made illegal in Australia, *The Conversation*, April 20 2019, viewed 15 October 2020, <https://theconversation.com/its-time-coercive-control-was-made-illegal-in-australia-114817>.
[47] Bilston G, Cehtel Y, Chilcott B, et al, 'Coercive control is a form of intimate terrorism and must be criminalised,' *The Guardian*, 6 October 2020, viewed 12 October 2020 <https://www.theguardian.com/commentisfree/2020/oct/06/coercive-control-is-a-form-of-intimate-terrorism-and-must-be-criminalised>.

> judiciary, other frontline responders, support workers, literally anyone whose work somehow relates to domestic and family violence – is trained about the new offence and coercive control more generally.
>
> The consequent change in thinking could lead to a cultural change that has long been missing in Australia's response to domestic and family violence. We need an entire system ready and willing to identify and appropriately respond to abuse without the incident-based blinders that currently obscure so much of it.[48]

Debate and differences of opinion surrounding the criminalisation of coercive control are not limited to academic, legal, or family and domestic violence researchers. Victim-survivors of family and domestic violence have a breadth of experiences, insights, and concerns that must be heard and harnessed in discussions about criminalising coercive control.

On 29 March 2022, the Western Australian Government commenced a community consultation process on the introduction of coercive control laws, through the release of its *Legislative Responses to Coercive Control in Western Australia: Discussion Paper* and accompanying fact sheet.[49]

In launching the discussion paper, the State government noted that:

> Considering new laws against coercive control raises complex legal, policy and social change issues. Legislative changes or other responses must benefit victim-survivors and not lead to adverse impacts, particularly for vulnerable members of the community.
>
> An important part of the consultation will consider what the current awareness of coercive control is in the community and how frontline responders can recognise these patterns of abuse. [50]

Relevantly, the discussion paper notes that Australian Attorneys-General and the New Zealand Minister for Justice agreed on 9 June 2021 to 'co-design national principles to develop a common understanding of coercive control and matters to be considered in relation to potential criminalisation':

> The national principles will be in two parts:
>
> 1. Part one will establish a common understanding of coercive control, including the impacts on women and vulnerable groups and best practice approaches to systems reforms.
>
> 2. Part two will address high level questions about the nature and scope of any criminal offence of coercive control and associated implementation issues.
>
> The MAG's Family Violence Working Group is leading the development of the national principles, in consultation with women's safety officials and the Women's

[48] Bilston G, Cehtel Y, Chilcott B, et al, 'Coercive control is a form of intimate terrorism and must be criminalised,' *The Guardian*, 6 October 2020, viewed 12 October 2020 <https://www.theguardian.com/commentisfree/2020/oct/06/coercive-control-is-a-form-of-intimate-terrorism-and-must-be-criminalised>.
[49] Government of Western Australia, *Legislative Responses to Coercive Control in Western Australia: Discussion Paper,* 29 March 2022, Office of the Commissioner for Victims of Crime; Government of Western Australia, *Legislative Responses to Coercive Control in Western Australia: Fact Sheet,* 29 March 2022, Office of the Commissioner for Victims of Crime.
[50] Government of Western Australia, 'Community to be consulted about tackling coercive control', *Media Statements*, 29 March 2022, accessed 29 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Community-to-be-consulted-about-tackling-coercive-control.aspx>.

> Safety Taskforce, which includes the Ministers for Women in all jurisdictions. The national principles will not consider the arguments for or against criminalisation.[51]

5.3 Some Australian jurisdictions include the association between family and domestic violence and suicide in strategic frameworks

5.3.1 The Victorian *Family Violence Multi-Agency Risk Assessment and Management Framework* highlights the prevalence of family and domestic violence among individuals who die by suicide

In March 2016, Victoria's Royal Commission (**the Commission**) into Family Violence delivered its report with 227 recommendations, including a recommendation to review and redevelop the state's Family Violence Risk Assessment and Risk Management Framework (**the Framework**), and to embed it in Victoria's *Family Violence Protection Act 2008*.[52]

Informed by a range of related reviews and engagement with 1300 stakeholders, the Framework's redevelopment resulted in the Victorian Family Violence Multi-Agency Risk Assessment and Management Framework (**the MARAM Framework**), which 'aims to address the gaps identified by the Commission'[53] and 'provides a system-wide approach to risk assessment and risk management.'[54]

> It creates the system architecture and accountability mechanisms required to establish a system-wide approach to and shared responsibility for family violence risk assessment and management. This is achieved by incorporating the Framework and accompanying principles and pillars into law, regulation, policy (through this MARAM Framework) and supporting materials and practice guides.[55]

The MARAM Framework highlights that in 'Victoria, one-third of people who die by suicide had a history of family violence,' and that 'family violence had been present for half of the women (identified as likely victim survivors) and one-third of men who died by suicide (identified as likely perpetrators).'[56] The MARAM Framework also incorporates a definition of family violence that highlights the connection between this violence and suicide which states that:

> Family violence perpetrated against Aboriginal people and communities includes a range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur in families, intimate relationships, extended families, kinship networks and communities.
>
> It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide. Family violence experienced by people in Aboriginal communities acknowledges the spiritual and cultural perpetration of violence by non-Aboriginal people against Aboriginal partners which manifests as exclusion or isolation from Aboriginal culture and/or community.[57]

[51] Government of Western Australia, *Legislative Responses to Coercive Control in Western Australia: Discussion Paper,* 29 March 2022, Office of the Commissioner for Victims of Crime, p. 5.
[52] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5.
[53] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5.
[54] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 3.
[55] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5.
[56] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 94.
[57] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 9.

The MARAM Foundation Knowledge Guide highlights the 'unique suicide risk factors' experienced by adolescent perpetrators of family violence which are 'compounded by increased risk of suicide for young people who have experienced family violence as victim survivors':

> The 2019 Commissioner for Children and Young People report *Lost, not forgotten* identified that:
>
> "… as children grow older and their trauma starts to manifest in challenging behaviour, disengagement from school, risk taking, violence or mental ill health, professionals lose empathy. The children become seen as the problem and referred to as 'difficult', 'needy', 'angry' and 'bad.'" [58]

In addition, the MARAM Foundation Knowledge Guide recognises the vulnerability the increased likelihood of suicide by children and young people who experience family and domestic violence … at all points along the journey from seeking safety to recovery and health' noting that:

> The risks of suicide are extremely high in young LGBTIQ people, particularly trans and gender-diverse young people. For LGBTIQ young people, this additional high risk is compounded by an increased risk if they have experienced family violence. …
>
> In Victoria, one-third of people who die by suicide had a history of family violence. Family violence had been present for half of the women (identified as likely victim survivors) …[59]

Importantly the MARAM Framework and Foundation Knowledge Guide requires specialist family and domestic violence staff to be 'trained to undertake Comprehensive assessment of risks, needs and protective factors for adult and children victim survivors' and acknowledges the limitations of traditional approaches to suicide risk assessment and encourages professionals to make use of:

> … emerging suicide prevention research and practice [which] places less emphasis on 'risk assessment', and more on identifying the drivers of suicidality and an individual's intent … [and] Also consider referrals to manage social distresses that increase suicide risk, such as employment, financial and housing issues and drug and alcohol addition/use. [60]

5.3.2 The Queensland *Suicide prevention framework for working with people impacted by domestic and family violence* acknowledges that 'suicides contribute the largest number of domestic and family violence deaths in Queensland each year' and that 'suicide is a risk factor across the entire spectrum of responses to people impacted by domestic and family violence'

The Queensland Government's *Suicide prevention framework for working with people impacted by domestic and family violence* (**the Queensland Suicide Prevention Framework**) was developed following a recommendation by the Queensland Domestic and Family Violence Death Review and Advisory Board (**the Board**), which is responsible for the systemic review of domestic and family violence deaths in Queensland:

[58] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 19 and 101.
[59] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 85 and 94.
[60] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 101.

> The Board reviewed two deaths (suicides) that occurred within women's shelters due to overdose of prescribed medication during 2016-17.
>
> As a result of this review, the Board recommended that a targeted suicide prevention framework, which accounts for the detection of, and response to, vulnerable individuals be developed and implemented within domestic and family violence shelters…
>
> In responding to this recommendation, the Queensland Government expanded the scope, to be applicable to all specialist practitioners working with people impacted by domestic and family violence. This decision was made in acknowledgement that suicide is a risk factor across the entire spectrum of responses to people impacted by domestic and family violence (including perpetrators), not only a risk for victim/survivors when they are in shelters.[61]

The Queensland Suicide Prevention Framework 'aims to guide practitioners who work with people impacted by domestic and family violence (including both victim/survivors and perpetrators) in Queensland, to effectively support people who may be at risk of suicide.'[62] Importantly, the Queensland Suicide Prevention Framework states:

> Domestic and family violence specialist workers are not expected to be researchers in suicide prevention. This Framework is intended to be used as a guide to inform best practice suicide prevention responses and referral to mental health researchers, to ensure clients and their children/dependants can access the support they need.[63]

The Queensland Suicide Prevention Framework identifies that suicide risk screening 'is used to identify whether there is risk of suicide present and should always be considered as part of routine risk screening processes when working with people impacted by domestic and family violence.' If the screening process identifies that there may be risk of suicide, it specifies that 'a thorough suicide risk assessment needs to take place by a clinician or relevant professional to inform appropriate safety strategies, referral options and treatment.'[64]

> Risk of suicide is not a static event, and may fluctuate as circumstances change for a person. Ongoing suicide risk screening is particularly important during periods of elevated risk, such as separation from a partner. For victim/survivors, this may also include contact with a violent perpetrator, or further exposure to domestic and family violence, and for perpetrators, it may include risk of the victim/survivor leaving the relationship or loss of control.[65]

[61] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 1-2.
[62] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 3.
[63] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 3.
[64] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 6.
[65] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 9.

The Queensland Suicide Prevention Framework also:

- provides guidance about talking to people impacted by family and domestic violence, noting that 'research suggests that direct questions about suicidal thoughts or behaviours are appropriate and do not increase the risk of suicide,' and that 'questions should gauge the presence of suicide intent, as well as if the client has a plan for suicide;'[66]
- details warning signs and risk factors which 'may indicate a person has elevated suicide risk and requires a thorough assessment;'
- identifies response and referral pathways, and when these should be used;[67] and
- provides information about working with diverse and/or high-risk groups.[68]

5.4 There is some recognition of the association between family and domestic violence and suicide in Western Australian strategic frameworks

5.4.1 *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* identifies that 'family and domestic violence towards children, young people, and adults is a primary cause of … suicide and self-harm'

On 22 July 2020, the State Government launched *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* (**Path to Safety**), Western Australia's strategy for reducing and responding to family and domestic violence.

The Path to Safety framework for change has 'four focus areas:'

- work with Aboriginal people to strengthen Aboriginal family safety;
- act immediately to keep people safe and hold perpetrators to account;
- grow primary prevention to stop family and domestic violence; and
- reform systems to prioritise safety, accountability and collaboration.[69]

> Path to Safety will be supported by three action plans 'that set out what needs to be done to achieve the long-term vision of all Western Australian's living free from family and domestic violence.' The First Action Plan, running from July 2020 to June 2022, initially focuses on 'actions to address the significant impact of COVID-19 on family and domestic violence in Western Australia.'[70]

Path to Safety identifies that 'family and domestic violence towards children, young people, and adults is a primary cause of … suicide and self-harm.'[71]

[66] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 9.
[67] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 13.
[68] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 18.
[69] Government of Western Australia, *Western Australia's Strategy to Reduce Family and Domestic Violence*, 2021.
[70] Government of Western Australia, *Western Australia's Strategy to Reduce Family and Domestic Violence*, 2021.
[71] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, Government of Western Australia, p. 17.

Recommendation 6: The Department of Communities, in consultation with key government and non-government stakeholders, considers this investigation and incorporates the findings of the investigation into strategic initiatives aimed at reducing the incidence and impact of suicide and self-harm associated with family and domestic violence, including incorporation into Path to Safety beyond the First Action Plan.

5.4.2 The Western Australian Suicide Prevention Framework acknowledges 'the role that addressing historical and current trauma and the social determinants of health have in suicide prevention'

Authored by the Mental Health Commission, the *Western Australian Suicide Prevention Framework 2021-2025* (**the WA Suicide Prevention Framework**) was developed for use 'as a guide by government, non-government, communities and private organisations, so that a coordinated approach can be taken to suicide prevention activity across Western Australia.'[72]

The WA Suicide Prevention Framework acknowledges 'the role that addressing historical and current trauma and the social determinants of health have in suicide prevention' including 'childhood trauma, family violence, poverty, insecure housing, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug use [and] … the impact of colonisation and systemic racism [on Aboriginal people].'[73]

The WA Suicide Prevention Framework also recognises that 'addressing the social determinants that drive hopelessness and have a marked impact on an individual's social connections, mental health and suicidality' is seen as 'the most pressing activity for suicide prevention in the near and long term' in some communities.[74]

The WA Suicide Prevention Framework further highlights the need for holistic supports for people experiencing vulnerability, including victims of family and domestic violence, noting that:

> Suicidal behaviour is complex, and there are many reasons why someone may be having suicidal thoughts. The early identification and providing people with a range of support and/or treatment options can reduce the risk of someone taking their life …
>
> [Proposed action] 4.5 Increasing access to appropriate mental health and support services for the specific needs of targeted vulnerable populations and including those relating to family and domestic violence, homelessness, alcohol and other drug use and/or trauma.[75]

[72] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 9.
[73] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[74] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 43.
[75] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 31.

In identifying that 'some populations and groups are more vulnerable to suicide and suicidal behaviour,' the WA Suicide Prevention Framework identifies that this includes:

- Aboriginal and/or Torres Strait Islander people;
- persons who have experienced abuse, historical or current trauma, conflict or disaster;
- refugees and migrants;
- prisoners and others in contact with the justice system;
- individuals who have made a previous suicide attempt and people suicide bereaved;
- LGBTI persons;
- children and young people; and
- rural and remote communities. [76]

5.4.3 The Department of Communities has released a draft Aboriginal Family Safety Strategy for consultation

Under Focus Area 1 of the State Government's *Path to Safety,* the first priority of the Department of Communities, informed by 'the voices of Aboriginal people who advocated strongly for a separate, stand-alone strategy' was to 'work with Aboriginal people and communities to co-design and implement a dedicated Family Safety Strategy.'[77]

Relevantly, Path to Safety identified 'the need for cultural healing' and that Aboriginal women and children's 'experiences of violence are compounded by service system responses that often fail to meet their needs'.[78] It noted that:

> In 2017, the Department reviewed the cases of 433 children in care (approximately 10% of children living in Out-of-Home-Care at that time), which included 226 Aboriginal children, 89% of these Aboriginal children had lived experiences of family violence.[79]

Path to Safety also highlighted that:

> Aboriginal people experience ongoing harm and trauma resulting from dispossession of land and identity, the Stolen Generations and systemic discrimination. These drivers of inequality and disadvantage are key to understanding Aboriginal people's disproportionate experience of family violence and why healing and cultural security need to be at the centre of responses for all Aboriginal people and communities. …
>
> We have listened to our stakeholders who told us that Aboriginal people, and particularly Elders and leaders, want to work in partnership with Government to lead the creation of strategies to address the drivers of violence and responses to family and domestic violence in their communities.

[76] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 48.
[77] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.
[78] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.
[79] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.

> The Aboriginal Family Safety Strategy will be co-designed and delivered with Aboriginal people to prevent and respond to family violence in ways that are culturally secure and responsive to the experiences of Aboriginal people across our State. At the centre of the approach will be recognition of and response to the diversity of WA's Aboriginal people. This diversity is experienced in terms of culture, kinship systems, roles of women and men, experience of trauma and geographical context. Taking a whole-of-community public health approach, the Aboriginal Family Safety Strategy will address the needs of victims and the accountability of the perpetrators to change behaviour.
>
> Access to cultural knowledge, protocols and a strong sense of identity, including women's and men's business, can prevent violence and improve wellbeing. In some cases, Aboriginal people's experiences of dispossession, racism and trauma have disrupted and eroded cultural practices that can prevent or stop violence. Recognising and building upon the existing strengths, resources and resilience of Aboriginal people and communities is critical to improving Aboriginal family safety and wellbeing.[80]

On 17 March 2022, the State Government released a draft of the Aboriginal Family Safety Strategy (**the Strategy**), developed by the Department of Communities in partnership with Dr Victoria Hovane, a Ngurin Ngarluma, Jaru, Gooniyandi woman, registered psychologist and managing director of Tjallara Consulting.[81] The draft strategy:

> … acknowledges that family violence is not part of Aboriginal culture, and has an aim of ensuring that all Aboriginal people in WA live safe and healthy lives free of family violence and that we are all part of that solution. …
>
> The Aboriginal Family Safety Strategy draft has been developed in close consultation with Aboriginal people and organisations to design a new approach that will keep children and families safe and allow them to heal.[82]

The draft Aboriginal Family Safety Strategy is underpinned by the values of 'self-determination', 'shared responsibility', 'culture and identity', 'cultural leaders, Elders and Traditional Owners' and 'respect'. [83] It also contains four key focus areas:

1. **Heal:** Ensure healing guides the delivery of family violence services and practice.[84]

2. **Recognise and support:** Recognise the unique roles and responsibilities of men and fathers and support them to build strong communities and support safe families.[85]

[80] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.
[81] Government of Western Australia, 'Aboriginal Family Safety Strategy released for comment', *Media Statements*, 17 March 2022, accessed 17 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Aboriginal-Family-Safety-Strategy-released-for-comment.aspx>.
[82] Government of Western Australia, 'Aboriginal Family Safety Strategy released for comment', *Media Statements*, 17 March 2022, accessed 17 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Aboriginal-Family-Safety-Strategy-released-for-comment.aspx>.
[83] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 7, 22-23.
[84] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, Department of Communities, Government of Western Australia, Perth, 2022, p. 25.
[85] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, Department of Communities, Government of Western Australia, Perth, 2022, p. 29.

3. **Transform:** Transform our service provision and reform our systems.[86]

4. **Build on and build up:** Use culture to build on foundations and build up futures through early intervention and prevention.[87]

Importantly, the draft Aboriginal Family Safety Strategy makes provision for 'ongoing monitoring and evaluation … to ensure continuous improvement, make progress and demonstrate change … [using those] data and metrics that are valued by Aboriginal people and communities.' [88]

The draft Strategy also recognises the need for a 'whole-of-Government approach to governance and [for its] implementation … [to] ensure actions are coordinated and building off one another'. [89]

5.4.4 The Family and Domestic Violence Response Team Model in place at the time of the investigation, is currently being redesigned

As part of Western Australia's approach in assessing and responding to family and domestic violence, FVIRs are provided to a multi-agency team comprising representatives from WA Police, the Department of Communities, and non-government organisations for triage, assessment, and further action. This model, known as the Family and Domestic Violence Response Team (**FDVRT**) model, became operational in February 2013.[90] It was therefore in place approximately four years prior to the commencement of the investigation period, when 711 (56 per cent) of the 1,276 FVIRs relating to the individuals who died by suicide were recorded.

The Department of Communities FDVRT Operating Procedures state:

> The FDVRT model aims to improve the safety of child and adult victims of family and domestic violence through a collaborative approach that focuses on timely and early intervention following a police call out to a family violence incident.[91]

In August 2020, the Department of Communities released the findings of the Family and Domestic Violence Response Team Review Report (**the Review Report**), summarising key themes and findings of a review undertaken into the operation of FDVRTs. The Review Report identified that 'the review of the FDVRT model was conducted as a result of the Ombudsman Western Australia (OWA) findings in relation to various child death and family and domestic violence (FDV) fatality reviews that identified recurring issues with the FDVRT model. In addition, known issues have been identified through operational and contract management feedback.'[92]

[86] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 35.
[87] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 41.
[88] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 49.
[89] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 50.
[90] Department of Communities, *Family and Domestic Violence Response Team Operating Procedures*, 2017, Government of Western Australia, Perth, p. 4.
[91] Department of Communities, *Family and Domestic Violence Response Team Operating Procedures*, 2017, Government of Western Australia, Perth, p. 5.
[92] Smith P, *Family and Domestic Violence Response Team Review*, 2020, Thirdforce Consultancy Services Pty Ltd, Subiaco East, p. 6.

The Review Report highlighted a number of findings, including that 'there is an urgent and critical need for a focussed team to support and guide the FDVRT with appropriate governance, monitoring, and compliance processes.'[93]

In July 2021, government stakeholders including the Minister for Police, Hon Paul Papalia and the Minister for Prevention of Family and Domestic Violence, Hon Simone McGurk met with the Director General, Communities to discuss interagency Family and Domestic Violence responses.'[94] During this meeting:

> … a Communities and WA Police Force recommendation to commence a project (the Project) to redesign the Family and Domestic Violence Response Teams service model was endorsed.
>
> Integral to the design of a new Family and Domestic Violence Response Teams Model is the formal inclusion of the Department of Justice in the process. Communities have established an interagency committee and project team consisting of Communities, WA Police Force and [Department of Justice] representatives to oversee the Project.
>
> The Project aims to design and implement a new integrated Family and Domestic Violence Response Teams service model that enables front line staff to deliver timely and coordinated intervention and support, to keep victims and their children safe, and hold perpetrators accountable.
>
> All agencies have agreed that a family and domestic violence informed approach will provide practical and culturally appropriate responses to family and domestic violence. As such, the Project will apply the nationally and internationally recognised Safe and Together Model, developed by the Safe and Together Institute.
>
> Embedding Safe and Together principles within operational practice will support Family and Domestic Violence Response Teams to focus on analysing the perpetrator's pattern of behaviour and view the perpetrator as the source of the harm to children and family functioning.[95]

During the Investigation, the Department of Communities advised the Office that:

> The FDVRT Project will be guided by the Aboriginal Family Safety Strategy, which is currently in development, and apply the principles and critical components of the nationally and internationally recognised Safe and Together model. Over the past two months, the project team has met fortnightly to develop a project plan which outlines the agreed principles and considerations which will guide the Project. This draft project plan was reviewed and endorsed by the committee on 2 September 2021.[96]

[93] Smith P, *Family and Domestic Violence Response Team Review*, 2020, Thirdforce Consultancy Services Pty Ltd, Subiaco East, p. 8.
[94] Personal Communication, Department of Justice, 4 November 2021 and Personal Communication, Department of Communities, 29 October 2021.
[95] Personal Communication, Department of Justice, 4 November 2021.
[96] Personal Communication, Department of Communities, 29 October 2021.

In December 2021, the Department of Communities most recently informed the Office that:

> … the project team have finalised the design of the enhanced Family Domestic Violence Response Team (FDVRT) service delivery model.
>
> The project team includes representatives from Communities, Justice and Police who have worked consultatively to implement the agreed deliverables, including;
>
> - The inclusion of Justice Officers in the co-located FDVRT
> - Development of a Central Support and Coordination Team to provide governance of the model and ensure ongoing continuous improvement across the structure, policy, process and training. This is a tripartite arrangement, staffed by representatives of Communities', Police and Justice.

Recommendation 7: The Department of Communities, Western Australia Police Force and the Department of Justice, in consultation with key government and non-government stakeholders consider this investigation and incorporates the findings of this investigation in the redesign of the Family and Domestic Violence Response Team Model including, but not limited to:

- the association between family and domestic violence and suicide, for women and children;
- the association between family and domestic violence and suicide for Aboriginal and Torres Strait Islander women and children; and
- the need to see and speak to children and adolescents who are exposed to family and domestic violence when engaging with families and assessing risk, including those alleged to be the perpetrator or instigator of parent-child conflicts.

5.5 Trauma greatly influences emotional, physical, and social wellbeing, and is an enormous driver of service need

5.5.1 For Aboriginal and/or Torres Strait Islander individuals, suicide prevention is inherently related to healing from trauma

Healing is 'an essential part' of the Aboriginal Empowerment Strategy, which identifies that 'Aboriginal people have said very clearly that healing and trauma must be addressed for social and economic outcomes to improve:'

> Healing is about addressing trauma. Trauma can be experienced at the individual level (such as abuse, neglect, or family separation), the household level (for example witnessing violence or self-harm), or the societal level (including dispossession and dislocation, racism, social exclusion, and the experiences of the Stolen Generations).

> Without healing, trauma can be passed on to others as intergenerational trauma, and new traumas may be created through cycles of disadvantage. The healing process allows individuals, families and communities to address the effects of past and ongoing trauma, and reduce its impacts on future generations.[97]

Aboriginal and/or Torres Strait Islander experts identify that addressing trauma is crucial to addressing suicide among Aboriginal and/or Torres Strait Islander people; 'any sustainable response must go to the deeper, underlying historical causes of hopelessness and despair, which contributes to suicide:'[98]

> These deeper causes include intergenerational trauma. Poverty, racism, social exclusion, substandard housing, and economic marginalisation of our communities are the legacies of colonisation.
>
> Indigenous suicide is different because it cannot be separated from the historical and related present-day situation of our peoples. Indigenous people from around the world share both similar histories and high rates of child, youth and other suicide …
>
> Our communities and cultures are sources of identity, values and practices that can help protect against suicide. Such strengths provide the foundation for a mix of short, medium, and longer-term action to turn the trajectory of Indigenous child and youth suicide deaths around.[99]

5.5.2 The Office identified that trauma was a driver of service need among the 68 women and children who died by suicide

The research literature identifies that trauma and 'exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need,' and that 'policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services.'[100]

Having identified that individuals with recorded histories of family and domestic violence demonstrated persistently higher levels of contact with State government departments and authorities, the Office identified that trauma was a driver of service need among the individuals who died by suicide.

5.5.3 High frequency utilisers of social support services have often been impacted by trauma

The research literature identifies that people impacted by trauma 'characteristically present at a wide range of services. They often have severe and persistent mental health and coexisting substance abuse problems and are frequently the highest users of the inpatient, crisis and residential services.'[101]

[97] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, Department of Premier and Cabinet, Perth, p. 11.
[98] Dudgeon P, Hirvonen T. and McPhee R, 'Why are we losing so many Indigenous children to suicide?' *The Conversation*, 29 March 2019, viewed 23 December 2021, <https://theconversation.com/why-are-we-losing-so-many-indigenous-children-to-suicide-114284>.
[99] Dudgeon P, Hirvonen T and McPhee R, 'Why are we losing so many Indigenous children to suicide?' *The Conversation*, 29 March 2019, viewed 23 December 2021, <https://theconversation.com/why-are-we-losing-so-many-indigenous-children-to-suicide-114284>.
[100] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 3.
[101] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 4.

> A large percentage of those seeking help across a diversity of health and human service settings have trauma histories severely affecting their mental and physical health and wellbeing. The impacts of trauma characteristically persist long after the trauma has ended. Although exact prevalence estimates vary, there is a broad consensus that many consumers who engage with public, private and community managed mental health and human services are trauma survivors and that their trauma experiences shape their responses to service providers.[102]

Researchers identify that individuals with experiences of trauma are across many human and social support service sectors, including:

- **Mental Health Services:** research has found that 'nine out of 10 people accessing mental health services have experienced trauma at some stage in their life.'[103] The Blue Knot Foundation highlights that the 'single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma.'[104]

- **Child protection systems:** researchers identify that 'children and families in the child welfare system 'experience high rates of trauma and associated behavioral health problems.'[105] The Australian Institute of Family Studies identifies that children and young people in care are likely to have been exposed to trauma and identifies them as 'one of the most vulnerable, disadvantaged and traumatised populations in the Australian community.'[106]

- **Police:** Experiencing trauma has been linked with increased rates of criminal behaviour:

> Research has demonstrated the interconnection between histories of violence and abuse, traumatic experiences, and criminal behaviour. This does not mean that violence and abuse in life creates or causes criminality in a simplistic or linear way, or that those who commit crime can merely 'blame it on' their previous experiences of violence, abuse, or neglect. Still, it does mean that there are complex interconnections between people's life experiences, opportunities, choices and chances, and their personal histories, including trauma histories. As one researcher observes: 'child abuse and neglect, poverty, sexual molestation, and witnessing violence are, among others, the most common risk factors for posttraumatic reactions, aggression, and antisocial behaviour.'[107]

[102] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 4.
[103] New South Wales Agency for Clinical Innovation, *Trauma-Informed Care and Practice in Mental Health Services*, 2021, viewed 21 October 2021 <https://aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services>.
[104] Middleton W, cited by Kezelman, C. and Stavropoulos, P. *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, Blue Knot Foundation, p. 30.
[105] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[106] Campo M and Commerford J, *Supporting young people leaving out-of-home care*, 2016, Australian Institute of Family Studies, Child Family Community Australia, p. 2-7.
[107] Randall M and Haskell L, 'Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping', *Dalhousie Law Journal*, 36(2), 2013, p. 516, citing Ardino V, *Offending Behaviour: The Role of Trauma and PTSD*, 2012.

- **The juvenile and criminal justice system**: 'Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.'[108] Further, the Australian Institute of Family Studies has stated that:

> [C]hildhood trauma exposure has been linked to involvement with the criminal justice system. A large study exploring adverse childhood experiences of serious, chronic and violent juvenile offenders and juveniles referred to the justice system for single non-violent offences found that every additional adverse childhood event experienced increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35%, even when other known risk factors for violent behaviour were accounted for (Hahn Fox et al., 2015).[109]

- **Homelessness:** AIHW identifies that 'half (54%) of [the] children and young people who received homelessness and child protection services [in 2016-17] were [also] experiencing family and domestic violence,' noting that this figure is higher than 'the 44% of children and young people' who are 'only' receiving homelessness services.[110]

- **Alcohol and other drugs treatment programs:** research identifies that over 80 per cent of individuals entering substance use treatment programs 'report having experienced a traumatic event in their lifetime,' and that the 'vast majority have experienced multiple traumas.'[111] Researchers further identify that post-traumatic stress disorder has a strong comorbidity with substance use problems.[112]

5.5.4 Trauma informed approaches acknowledge and attend to the effects of trauma: this has significant implications for service provision

The Office reviewed a diverse and 'rapidly growing research base' leading to new understandings of trauma, and identified that correspondingly, this research 'also has major implications for service-provision.'[113] In this context, the Office identified that there has been increased attention to the concept of trauma informed approaches 'to help services attend to the effects of trauma, and its links to health and behaviour, so as to create safe spaces that limit the potential for further harm.'[114]

In undertaking this work, the Office has consulted with State government departments and authorities, and key stakeholders in the family and domestic violence sector. The Office has heard that, while awareness of the need to account for trauma in service provision is becoming more prevalent in Western Australia, more knowledge is needed to understand how this may be used to enact meaningful change.

[108] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[109] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 7.
[110] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018,* 2018, p. 65.
[111] Mills K, 'Trauma and substance use,' Presentation at the Western Australian Network of Alcohol & other Drug Agencies WA AOD Conference, March 2018, viewed 21 October 2021 <https://cracksintheice.org.au/pdf/webinar-trauma-substance-use.pdf>.
[112] Forbes D, 'Substance use and mental health consequences of trauma and implications for assessment and treatment,' 2018, Western Australian Alcohol and Other Drug Conference, 21 March 2018.
[113] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxx.
[114] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.

6 The need for trauma-informed, culturally secure family and domestic violence services in Western Australia

6.1 Trauma and its impact

6.1.1 Trauma

The research literature identifies that trauma is 'both the experience of, and a person's response to, an overwhelmingly negative event or series of events'[115] that are emotionally disturbing or life-threatening:[116]

The Blue Knot Foundation, Australia's National Centre of Excellence for Complex Trauma, identifies that trauma 'is a state of high arousal in which severe threat or the perception of severe threat overwhelms a person's capacity to cope. It comprises a range of events, situations and contexts. These include natural disasters, accidents, betrayal in interpersonal relationships, and diverse forms of abuse.'[117]

6.1.2 Trauma survivors display extraordinary strength and resilience, and recovery from trauma is possible

Researchers have identified that 'we know far more' about trauma and post-traumatic symptoms 'than we do about resiliency' arising from family and domestic violence.[118] Increasingly, researchers have found that recognising an individual's strength is vital in responding to trauma:

> … a list of symptoms tells us little about the tremendous strengths and resources battered women draw on to recover from domestic violence. The pain individuals experience from domestic violence should not be minimized. Yet, it does not have to be the centerpiece of one's identity. Standing alongside the entire range of debilitating effects of trauma, most survivors display a stunning capacity for survival and perseverance. Growth and pain, therefore, are not necessarily mutually exclusive, but instead are inextricably linked in recovery from trauma.[119]

Acknowledging the strengths and perseverance of trauma survivors is also an important component of recovery from trauma. Orygen, the National Centre of Excellence in Youth Mental Health, has highlighted the importance of ensuring that the strengths of young people, their families and carers are 'recognised, built on, and validated [and] … used to empower them in the development of their treatment.'[120]

[115] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.
[116] Centre for Health Care Strategies, 'Understanding the Effects of Trauma on Health,' 2017, p. 1.
[117] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 45.
[118] Anderson K, Renner L and Danis F, 'Recovery: Resilience and Growth in the Aftermath of Domestic Violence,' *Violence Against Women*, 2012, 18(11), p. 1280.
[119] Anderson K, Renner L and Danis F, 'Recovery: Resilience and Growth in the Aftermath of Domestic Violence,' *Violence Against Women*, 2012, 18(11), p. 1280.
[120] Orygen National Centre of Excellence in Youth Mental Health, *Clinical practice in youth mental health: What is trauma-informed care and how is it implemented in youth healthcare settings?*, 2018, p. 2.

The Blue Knot Foundation emphasises that elevating the voices of survivors of trauma and incorporating messages of 'optimism and hope' is vitally important when providing recovery and support services to survivors of childhood abuse, including family and domestic violence:

> Feedback from adult survivors of child abuse suggests that a sense of optimism regarding the process of recovery is far from common within many areas of existing service provision (this is when childhood trauma is recognised at all). Indeed, the experience of many survivors is that an opposite message is conveyed. This is not only a harmful message to transmit, but in light of the now solid research findings to the contrary, an illegitimate one. Resolution of trauma, including of adverse childhood experiences, is now shown to be possible, and best-practice trauma informed care should consistently convey this message in all respects and at all levels.[121]

Researchers highlight that recovery from trauma is possible, and that 'many people go on to lead fulfilling lives.'[122] Research identifies that impacts of even the most severe trauma 'can be resolved,' and that 'negative intergenerational effects' of trauma 'can be intercepted … when mental health and human service delivery … reflect the current research insights.'[123]

The research literature documents the need to overcome the societal myth that survivors of childhood abuse are 'damaged' and 'not capable of living a normal life.'[124] Noting that:

> [M]any survivors manage to live their lives and succeed in a range of professions and all strata of society. In so doing, they show great strength and courage. Despite the impacts of childhood abuse, adult survivors resist the effects in many ways, and find strategies to help with healing and developing a new sense of self.[125]

The Blue Knot Foundation further highlights the concept of post-traumatic growth, whereby 'a person develops greater inner strength as a result of their journey through trauma' and, in doing so, 'develop[s] beyond recovery':[126]

> … if you are a survivor or are supporting a survivor, the concept of post traumatic growth may seem unachievable at the moment but knowing that it is possible can also be empowering.[127]

[121] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 15.
[122] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[123] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxviii.
[124] Henderson C, and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 52.
[125] Henderson C, and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 52.
[126] Blue Knot Foundation, *Healing and Resilience*, 2021, viewed 20 October 2021 <https://blueknot.org.au/resources/coping-strategies-impacts-and-healing/healing-and-resilience/>.
[127] Blue Knot Foundation, *Healing and Resilience*, 2021, viewed 20 October 2021 <https://blueknot.org.au/resources/coping-strategies-impacts-and-healing/healing-and-resilience/>.

6.1.3 The concept of resilience is crucial to understanding how individuals are affected by trauma

In recognising that individuals 'demonstrate a range of reactions to traumatic events, tragedy and stress, researchers have tried to understand why some people succeed in the face of hardship and risks where others experience ongoing distress or illness.'[128] In this context, researchers identify resilience as 'a crucial construct in understanding the traumatic stress response because both trauma and resilience are interdependent processes that influence one's overall health.'[129]

Resilience refers to 'the capacity of human beings of any age to survive and thrive in the face of adversity.'[130] Increasingly, researchers have sought to understand 'what helps resilient individuals overcome adversity in the hope that the trait may be fostered in others.'[131]

> Resilience has been defined as 'a dynamic process encompassing positive adaptation within the context of significant adversity.' Resilience is not a personal trait that individuals do or do not possess (thus, the term 'resiliency' is best avoided because it connotes an individual characteristic), but rather a product of interacting factors—biological, psychological, social, and cultural—that determine how a child responds to traumatic events.[132]

Research identifies that the impacts of abuse, neglect, and other potentially traumatic events 'differ enormously depending on a complex interplay of factors.' These factors include 'disposition; bio-psychological factors; family environment and other supports; peers; security; positive parent/child attachment; and previous history of support or abuse, including duration, frequency and nature of abuse.'[133]

Resilience can exist – and be cultivated – in individuals and communities. For children in particular, 'cognitive development/problem solving skills,' 'self-regulation,' and 'relationships with caring adults' can assist in developing key elements of resiliency.[134]

Researcher Michael Ugnar, an expert resilience theory, is 'cautious when naming the magic elements' that make an individual resilient,[135] and instead highlights the responsibilities of families, communities, and governments to provide resources that foster resilience:

> *"In the context of exposure to significant adversity, resilience is both the capacity of individuals to* **navigate** *their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to* **negotiate** *for these resources to be provided in culturally meaningful ways."*

[128] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[129] Ferrara N, *In Pursuit of Impact: Trauma- and Resilience-Informed Policy Development*, 2018, Lexington Books, Lanham, p. 35.
[130] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[131] Administration for Children and Families, 'Resilience,' U.S. Department of Health and Human Services, Washington, 2021, viewed 19 October 2021 <https://www.acf.hhs.gov/trauma-toolkit/resilience>.
[132] Bartlett, J. and Steber, K., 'How to Implement Trauma-informed Care to Build Resilience to Childhood Trauma,' *Child Trends,* Bethesda, 2019, viewed 19 October 2021 <https://www.childtrends.org/publications/how-to-implement-trauma-informed-care-to-build-resilience-to-childhood-trauma>.
[133] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[134] Substance Abuse and Mental Health Services Administration, *Childhood Resilience*, 2019, viewed 19 October 2021 <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/childhood-resilience>.
[135] Ugnar M, *2014 Thinker in Residence Report by Michael Ugnar*, 2014, Commissioner for Children and Young People Western Australia, Perth, p. 7.

> This definition shifts our understanding of resilience from an individual concept, popular with western-trained researchers and human services providers, to a more relational understanding of well-being embedded in a social-ecological framework. Understood this way, resilience requires individuals have the capacity to find resources that bolster well-being, while also emphasizing that it's up to families, communities and governments to provide these resources in ways individuals value. In this sense, resilience is the result of both successful navigation to resources and negotiation for resources to be provided in meaningful ways.[136] [original emphasis]

Ugnar has identified that in general, resilience 'is a process' rather than the 'static trait of an individual.' Described 'as the interaction between a child's personal strengths and the child's environment,' resilience 'will almost always depend on the child's ability to seek and find what he or she needs … It is up to the child's community to provide the child with the protective factors that help him to cope with stress.'[137]

6.1.4 Complex trauma/toxic stress

In defining trauma, researchers differentiate between simple and complex trauma. Simple trauma is the term used for single-incident trauma involving experiences or events 'that are life threatening and/or have the potential to cause serious injury'[138] and are generally unexpected. Simple trauma can include experiences such as being in a car accident, house fire, natural disaster, fighting in a war, or experiencing assault in adulthood.[139] Researchers further identify that 'there are also generally supportive and helpful community responses to the people who have experienced [simple or single incident] trauma.'[140]

> [S]ingle incident trauma such as accidents or natural disasters are more likely to be public events. Other people know about or share the trauma so there is more community acceptance. This can provide validation and reduces secrecy and shame. Single incident events usually have a clear beginning and end. Once the event is over, survivors can reach a place of safety and may be able to seek help and recover.[141]

Complex trauma is often ongoing and interpersonal, occurring in relationships that are meant to be safe:

> **Complex Trauma** occurs as a result of traumatic stressors that are interpersonal – premeditated, planned and perpetrated by one human being on another. It is particularly damaging if it occurs in childhood. These actions can be both violating and exploitative of another person.[142]

[136] Resilience Research Centre, *What is Resilience,* 2021, viewed 19 October 2021, <https://resilienceresearch.org/about-resilience/>.
[137] Ugnar M, *2014 Thinker in Residence Report by Michael Ugnar*, 2014, Commissioner for Children and Young People Western Australia, Perth, p. 7.
[138] Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[139] Blue Knot Foundation, *What is Complex Trauma*, 2021, viewed 11 October 2021, <https://blueknot.org.au/resources/understanding-trauma-and-abuse/what-is-complex-trauma/>; Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[140] Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[141] International Society for the Study of Trauma and Dissociation, *Trauma and Complex Trauma: An Overview*, 2020, viewed 11 October 2021 <https://www.isst-d.org/public-resources-home/fact-sheet-i-trauma-and-complex-trauma-an-overview/>.
[142] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.

As interpersonal violence or trauma 'often occurs in secrecy and is steeped in shame, survivors often struggle to have their experience validated,'[143] with individuals 'often feel[ing] disconnected from the support of others:'[144]

> [C]omplex trauma is characteristically the product of overwhelming stress that is interpersonally generated. Its multiple impacts include those affecting a person's 'sense of self'. As interpersonal violence and abuse often occur in secrecy and are steeped in shame, survivors often struggle to have their experience recognised and validated by others. Trauma occurring in the context of interpersonal violence, either covert or overt, often brings about complex and chronic psychological and physiological injuries.[145]

Complex trauma is also known as 'toxic stress' in the research literature. The Australian Childhood Foundation has highlighted that for children:

> **Toxic stress** results from intense experiences that target the child directly and carry with them intentional messages of intimidation, fear, shame and abuse of power. It is overwhelming of the child's internal psychological, emotional, relational and physiological resources. It too can be sustained over a period of time. However, the intensity with which it occurs can also mean that a brief or one-off experience of it can significantly affect a child and young person. Examples of toxic stress are child sexual abuse, physical abuse and bullying. As a result, children and young people's physiological systems remain activated without relief. It causes sustained disintegrative effects in both the structure of the brain and communication between the body and brain. The destructive effects of toxic stress can be reduced by co-ordinated and deliberate interaction between young people and a network of supportive and trained adults. Often, therapeutic and individually tailored support plans are imperative in reconfiguring the child or young person's ongoing response to future developmental challenges.
>
> Toxic stress results from significantly adverse and pervasive experiences for children and young people, including
>
> - child abuse;
> - chronic neglect;
> - family violence;
> - rejection or bullying by peers; and,
> - racial discrimination and/or harassment.
>
> Because the brains and bodies of children and young people are so malleable, high impact stress and toxic stress are faster to manifest. They leave deeper tracks of damage. In these circumstances, children's brain and body systems will be harmed, affecting the way they react and relate to others and their physical environment.

[143] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 14.
[144] Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[145] Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 6.

> High impact and toxic stress reduces the capacity of the thinking part of children's brain to shape the way they react to challenges in their environment. As a result, children and young people appear to behave instinctively and sometimes inappropriately, without knowing why. They are also not able to easily influence their feelings when faced with perceived threat or increases in their experience of stress.
>
> It impairs the growth and activity of the connecting structures between the left and right hemispheres of the brain. As a result, children find it difficult to know, name and express their feelings. They can find it difficult to read social cues and respond in social exchanges. It increases children and young people's base arousal level such that they live in a constant state of vigilance and heightened alarm. As such, vulnerable children and young people are easily triggered by seemingly minor issues. Their responses are often seen as 'out of the blue' or 'over reactions' to situations.
>
> High impact stress and toxic stress lock down children and young people's capacity to adapt to change in their environment. They are more likely to use fixed and repetitive behavioural routines in situations where they feel distress and unease. These routines involve movements and actions that feel familiar and comforting to them – even if they are destructive or harmful to others.
>
> These children and young people lack the adaptability and flexibility necessary to respond differentially to varying situations and contexts. They have a limited range of coping strategies. Whilst these strategies may have been effective in assisting them to survive in unsafe situations, they are often inappropriate responses in situations where there is an absence of danger.[146]

6.1.5 Intergenerational trauma

Trauma can also extend from one generation to the next. In 1966, researchers identified 'high rates of psychological distress among children of holocaust survivors,'[147] with subsequent research showing that 'not only traumatic experiences, but also resilience patterns can be transmitted to and developed by the second generation.'[148]

> When people who have experienced or witnessed trauma have not had an opportunity to heal from that trauma, it can be transferred to the next generation. This is known as intergenerational trauma.[149]

When trauma is transferred across a number of generations, 'it is known as transgenerational trauma' and extends beyond individuals to families and communities.[150]

[146] Tucci J, Mitchell J, Lindeman M et al, *Strengthening Community Capacity to End Violence: A Project for NPY Women's Council*, 2017, NPY Women's Council and Australian Childhood Foundation, p. 17-18.
[147] Menzies P, 'Intergenerational Trauma and Residential Schools,' *The Canadian Encyclopedia*, 2020, viewed 12 November 2021, <https://www.thecanadianencyclopedia.ca/en/article/intergenerational-trauma-and-residential-schools>.
[148] Braga L, Mello M. and Fiks J, 'Transgenerational transmission of trauma and resilience: a qualitative study with Brazilian offspring of Holocaust survivors,' *BMC Psychiatry*, 2012, 12(134), doi:10.1186/1471-244X-12-134.
[149] Blue Knot Foundation, *Intergenerational Trauma: Fact Sheet*, 2021, p. 1.
[150] Blue Knot Foundation, *Intergenerational Trauma: Fact Sheet*, 2021, p. 1.

In Australia, transgenerational trauma impacts Aboriginal and Torres Strait Islander people who have experienced trauma because of 'colonisation, including the associated violence and loss of culture and land, as well as subsequent policies such as the forced removal of children. In many Indigenous families and communities, this trauma continues to be passed from generation to generation with devastating effects.'[151]

6.1.6 Trauma can have long-term impacts upon individuals

Researchers identify that the long-lasting adverse effects of an event 'are a critical component of trauma,'[152] noting:

> These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic events and the effects.[153]

As a result of advances in diverse and numerous fields,[154] there is a growing body of evidence showing that experiencing trauma or traumatic events can have significant impacts upon individuals, raising their risk of long-term physical and behavioural health issues.[155]

In the field of neuroscience, a multidisciplinary science examining the structure and function of the nervous system, scientists have examined a continuum of automatic, survival-based behaviours that are innate, hard-wired and automatically activated in response to the perception of threat:

> *Arousal* is the first step in activating the defense cascade; *flight or fight* is an active defense response for dealing with threat; *freezing* is a *flight-or-fight* response put on hold; *tonic immobility* and *collapsed immobility* are responses of last resort to inescapable threat, when active defense responses have failed; and *quiescent immobility* is a state of quiescence that promotes rest and healing. Each of these defense reactions has a distinctive neural pattern mediated by a common neural pathway.[156]

The Australian Childhood Foundation has also highlighted that, with respect to children experiencing toxic stress:

> Children and young people affected by high impact stress and toxic stress find it difficult to make meaning from their experiences. They have few or no effective internal maps to guide their actions. As a result, they react rather than respond.
>
> Their beliefs about themselves are determined by the very people who violate them. They hold onto ideas about relationships which are not helpful to them in their communication with peers and other adults like teachers. They can find it

[151] Australians Together, *Intergenerational Trauma*, 2021, viewed 12 November 2021 <https://australianstogether.org.au/discover/the-wound/intergenerational-trauma/>.
[152] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 8.
[153] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 8.
[154] Shonkoff J and Garner A, 'The Lifelong Effects of Early Childhood Adversity and Toxic Stress,' *Pediatrics*, 2012, 129(1), p. e232, viewed 11 October 2021, <http://www.pediatrics.org/cgi/doi/10.1542/peds.2011-2663>; Centre for Health Care Strategies, *Understanding the Effects of Trauma on Health*, 2017, p. 1.
[155] Centre for Health Care Strategies, *Understanding the Effects of Trauma on Health*, 2017, p. 1.
[156] Kozlowska K, Walker P and McKeabm L, et al, 'Fear and the defense cascade: Clinical implications and management,' *Harvard Review of Psychiatry*, 2015, 23 (4), viewed 12 October 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495877/>.

> difficult to see adults as supportive. They are cautious about being hurt and are more likely to stay closed to the development of new connections or relationships.
>
> They do not easily understand or engage with consequential learning. Their brains are so over-activated that they are able to take in very little and not learn new information easily. In particular, their memory systems continue to remain under stress. They fail to consolidate new learning. Their working memory for even the easiest set of instructions can be severely compromised.
>
> Children and young people affected by high impact stress and toxic stress experience the present with little reference to their past, even though their behaviour, feelings and physiology are affected by their experiences of violation. They do not have access to the qualities that make them who they are. They have a transient sense of their own identity. Their future is without plans or a sense of possibility.[157]

6.1.7 Adaptive coping mechanisms may serve trauma survivors in the short term, but can compromise health and wellbeing in the long term

Scientists highlight that, unlike animals, humans are often not 'able to restore their standard mode of functioning once the danger is past,' and that people 'may find themselves locked into the same, recurring pattern of response tied in with the original danger or trauma.'[158]

The research literature suggests that experiencing trauma can result in the development of neurological and psychological symptoms,[159] and '[i]n the absence of treatment, [these] trauma-related difficulties and their effects tend to persist into adolescence and adulthood and become difficult to reverse'.[160] The brain's 'remarkable adaptiveness'[161] and the ability of the nervous system 'to change its activity in response to intrinsic or extrinsic stimuli by reorganizing its structure, functions, or connections'[162] can mean that, 'if the initial trauma is not resolved and the person has not recovered, he/she can be repeatedly "triggered" into survival responses by seemingly minor stressors.'[163] These adaptive coping mechnisms:

> … emerge in response to adversity [and] are rooted in the biological imperative to survive life-threatening situations and cope with the aftermath of trauma. Often formed during childhood, these adaptations are embedded in neural networks, functioning outside of conscious awareness and operating even after the trauma exposure has ended. The brain stores trauma memories as part of a protection strategy. When memories quickly (and sometimes frequently) intrude into the present as upsetting thoughts, emotions, sensory memories, bodily sensations, or flashbacks, the original sense of fear, as well as the associated self-protective, survival strategies are activated. Adaptive behaviors such as aggression, spacing-out, avoidance, and distrust become automatic responses to the slightest cue of danger. For example, trauma survivors' sensitivity to loud noises,

[157] Tucci J, Mitchell J, Lindeman M et al, *Strengthening Community Capacity to End Violence: A Project for NPY Women's Council*, 2017, NPY Women's Council and Australian Childhood Foundation, p. 18.
[158] Kozlowska K, Walker P and McKeabm L, et al, 'Fear and the defense cascade: Clinical implications and management,' *Harvard Review of Psychiatry*, 2015, 23 (4), viewed 12 October 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495877/>.
[159] For example, see: van der Kolk B, *The Body Keeps Score: Brain, mind and body in the healing of trauma*, New York, 2014; Schore A, 'Dysregulation of the Right Brain: A Fundamental Mechanism of Traumatic Attachment and the Psychopathogenesis of Posttraumatic Stress Disorder', *Australian and New Zealand Journal of Psychiatry*, 2002(36), p. 9-30; Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice.
[160] Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice, p. 1.
[161] Rosenzweig J, Jivanjee P, and Brennan E, et al, 'Understanding Neurobiology of Psychological Trauma,' *Pathways Research and Training Centre*, 2017, p. 2. <https://www.pathwaysrtc.pdx.edu/pdf/projPTTP-neurobiology-tip-sheet.pdf>.
[162] Mateos-Aparicio P and Rodriguez-Moreno A, 'The Impact of Studying Brain Plasticity,' *Frontiers in Cellular Neuroscience*, 2019, viewed 12 October 2021 <https://www.frontiersin.org/articles/10.3389/fncel.2019.00066/full>.
[163] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* Blue Knot Foundation, 2018, p. 11.

> odours, physical proximity to others, and touch can instantaneously activate adaptive reactions.[164]

In examining how people experience trauma, the Blue Knot Foundation identifies that the basic experience of trauma can involve experiencing 'the destruction of the predictable foundation of everyday life which the non-traumatised person takes for granted.'[165]

Where an individual's normal coping responses 'provide a sense of control, connection, meaning and safety,'[166] trauma interferes with a person's ability to cope:[167]

> Trauma overwhelms a person's ability to cope when faced with threat, or when they believe there is a serious threat confronting them ...
>
> Trauma is a state of high arousal which interrupts connection ('integration') across a wide range of functioning. It disrupts the capacity for systems of the body to work together. This can negatively affect a person's physical and psychological health in many ways.[168]

Researchers identify that people who experience trauma may develop ways of coping that allow them to survive and function day to day,[169] and 'manage the psychosocial and physiological disruption which trauma causes.'[170]

> Children, like adults, develop coping strategies to protect them from being overwhelmed and help them manage the physiological and psychological effects of the dysregulated arousal, emotions and behaviour which occur with trauma. Such coping strategies are often creative and effective in the short to medium term, but risky and can damage health in the longer term.[171]

Coping strategies may assist a person to manage dysregulation and overwhelming stress arising from trauma in the short term. Often though, the long-term effects of trauma prove to be 'pervasive and cannot be compartmentalised.[172] Accordingly, over time, the coping strategies used by a person who has experienced trauma, may decrease in their effectiveness, and cause trauma-organised 'profound neurobiological adaptations' which may be injurious to their health.'[173] For example, coping strategies such as 'alcohol and drugs, self-harm, over- or under-eating or over-working'[174] can impair individuals wellbeing and health later in life:

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[164] Rosenzweig J, Jivanjee P, and Brennan E, et al, 'Understanding Neurobiology of Psychological Trauma,' *Pathways Research and Training Centre*, 2017, p. 2. <https://www.pathwaysrtc.pdx.edu/pdf/projPTTP-neurobiology-tip-sheet.pdf>.
[165] Kezelman, C. and Stavropoulos, P. *Talking about Trauma: Guide to conversations and screening for health and other service providers,* Blue Knot Foundation, Milsons Point, 2018, p. 14.
[166] The Sexual Trauma & Abuse Care Centre, *Neurobiology of Trauma*, 2016, viewed 11 October 2021, <http://stacarecenter.org/wp-content/uploads/2015/09/The-Care-Center-Neurobiology-of-Trauma-Nov-2016.pdf>.
[167] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.
[168] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 7.
[169] The National Child Traumatic Stress Network, *Complex Trauma: Effects*, 2021, viewed 11 October 2021, <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects>.
[170] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 34.
[171] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 45.
[172] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxxi
[173] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxxi
[174] Blue Knot Foundation, *What is Complex Trauma,* 2021, viewed 11 October 2021, <https://blueknot.org.au/resources/understanding-trauma-and-abuse/what-is-complex-trauma/>.

> Many traumatised people adopt extreme coping strategies in order to manage anxiety and overwhelming emotional distress including: suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, and dissociation. Many coping strategies become risk factors for later physical health issues.[175]

Researchers identify that research 'can now connect the psychobiology of trauma to the social determinants of health,' or the conditions in which people 'grow, live, work and age' which shape their health.[176] The most prominent, comprehensive, and systematic study examining this connection is the Adverse Childhood Experiences (**ACE**) study conducted in the United States:

> This longitudinal study draws on over 17000 participants, and with reference to various categories of 'adverse' childhood experience and household dysfunction, explores the extent to which such experience affects subsequent adult health.
>
> Cohort members of the ACE study are predominantly white middle-class, have generally had some college experience, and do not show any obvious markers of social disadvantage. Yet the two major findings of this study are that adverse childhood experiences are 'vastly more common than recognised or acknowledged', and that they powerfully impact both mental and physical health 'a half-century later'.
>
> In fact the ACE study charts the translation of traumatic childhood experience into both emotional disorder and organic disease later in life. The study establishes 'that time does not heal some of the adverse experiences [found to be] so common in the childhoods of a large population of middle-aged, middle class Americans. One does not 'just get over' some things …
>
> A further key finding of the ACE study is the extent to which adult health problems on the part of those who had adverse experiences as children stem from strategies, coping mechanisms and behaviour which were initially protective attempts to deal with the adversity experienced.[177]

The epidemiological results of the ACE study 'are authoritative in their magnitude' and correlate decisive links 'between adverse childhood experiences and subsequent adult health problems.'[178] Further research has repeatedly replicated the findings of the ACE study. For example, research has identified that a history of childhood trauma is '[t]he single most significant predictor' of subsequent contact with the mental health system.'[179]

[175] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 17.
[176] Commission on Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health*, 2008, World Health Organisation, Geneva, p. 1.
[177] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[178] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[179] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 46.

The ACE study established that 'personal solutions' in the form of 'coping mechanisms to deal with childhood trauma are converted over time into adult health problems,' as initially protective attempts to deal with adversity 'lose their protective function,' and 'actively undermine adult well-being.'[180] In this context, the ACE study and subsequent research has located the 'roots of major public health problem[s]' in the experiences of trauma and adverse events in childhood.[181]

6.1.8 Adaptations arising from trauma may influence behaviour and lead to difficulties engaging with service systems

Dr Sandra Bloom, former President of the International Society for Traumatic Stress Studies and Chair of the Campaign for Trauma-Informed Policy and Practice in the United States, has highlighted that 'many people who present to social service and health organisations, especially 'high utilisers', will have a trauma history, and this may lead to difficult or discordant interactions.'[182]

Dr Bloom describes how 'clients presenting in mental health, substance abuse, and other social service settings' are likely to be impacted by exposure to chronic stressors and significant experiences of childhood adversity, and that this also influences behaviours and responses in service provision settings:[183]

> … they have been repeatedly exposed to danger and now may have difficulty keeping themselves safe… Clients who have been repetitively hurt within the context of close, interpersonal relationships, often have difficulty discerning who can be trusted and who cannot because failures of trust characterise their interpersonal history…
>
> As a result of the exposure to chronic stress, clients are frequently chronically hyperaroused, responding to even minor stressors as major stressors… One of the responses to chronic hyperarousal in our clients may be an increase in aggression toward self and/or others. Repetitively traumatised clients have significant difficulties in managing distressing emotions…
>
> Under recurringly traumatising conditions, it is difficult to maintain a clear and healthy sense of identity. As a result, clients often appear contradictory: they often do not act on what they think, or their actions contradict what they say. Their strongly held moral beliefs may not consistently guide their actions. As a result of their toxic experiences with other people, clients frequently lack good communication skills and have difficulty in being both direct and diplomatic. As a result, their communication style may be indirect and covert and may end up creating more problems than it solves …[184]

[180] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[181] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[182] Bloom S (2019) and Mautner et al (2013) cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[183] Bloom S, 'Trauma-informed systems transformation: Recovery as a public health concern', 2007, cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 61-62.
[184] Bloom S, 'Trauma-informed systems transformation: Recovery as a public health concern', 2007, cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 61-62.

Where Dr Bloom highlights the 'weight of accumulated trauma experiences that people carry when they enter social services settings,' Western Australian researchers Dr Peter Smith and Lisette Kaleveld also highlight that this can include traumas 'from their distant as well as immediate history:'[185]

> For example, often workers will not be aware that prior to presenting at their service a client perhaps had been asked to leave the homeless shelter, denied funds from Centrelink or had not slept properly or eaten well for days. Their first interaction with a new service may involve extensive paperwork or demands to provide information about personal histories (that may include covering past traumas).
>
> It is therefore understandable that the person's ability to regulate their emotion at this point may be compromised. If anything about the present interaction is triggering, things do not go their way, or a person has just had enough, they may vent their anger at the worker in front of them. The symptoms and behaviours that trauma survivors present may result in their being turned away (MHCC, 2013), which may be then experienced as abandonment which might exacerbate any trauma history.[186]

As survival responses 'operate outside conscious awareness,' and 'people still affected by trauma experience continuing high sensitivity to seemingly minor stressors or "triggers;"' a traumatised person can therefore 'often be repeatedly triggered:'[187]

> To the observer who does not know or remember this, a person may seem overly reactive for no apparent reason. It can be easy to misinterpret their reaction/s, and respond inappropriately in attitude and behaviour.[188]

The research literature highlights that changes related to trauma and the brain's stress response can drive the behaviour of traumatised individuals. When considered without context, this can result in authorities misperceiving traumatised individuals:

> Traumatized individuals tend to be hypervigilant and hypersensitive to perceived threats, and they tend to overreact to such threats, often violently. This extreme reaction becomes the focus of police attention. For example, a traumatized person may mask anxiety with an extreme bravado, which police view as arrogance or a lack of caring instead of the psychological defense mechanism that it is (Arroyo, 2001). Also, the brain's impaired regulation of the stress response makes it difficult, if not impossible, for traumatized individuals to calm themselves down, even when it would be in their best interest to do so, which makes them seem more aggressive (Van der Kolk et al., 2009). In addition, associated difficulties such as substance abuse can also become a focus of police attention, with no thought about whether underlying psychiatric difficulties might have contributed to such substance abuse.[189]

[185] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[186] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[187] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 11.
[188] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 11.
[189] Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice, p. 11.

In this context, researchers identify that 'challenging behaviours' can be adaptive responses to trauma.[190] For example, a 'mistrust of authority figures and wariness of professional helpers,' rather than being interpreted as 'hostility, lack of motivation or resistance to services', may be viewed as a normal, 'protective reaction when an individual feels vulnerable.'[191] In this sense, trauma informed approaches serve to 'normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance.'[192]

6.1.9 Trauma exposure is widespread: millions of Australians have experienced abuse and violence

The research literature identifies that trauma is widespread – 'traumatic experiences are common, with people often having multiple adverse experience across their life.'[193] Trauma:

> … occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders.[194]

General population research conducted by the World Health Organisation over 24 countries, with a combined sample of almost seventy thousand participants, identified that over 70 per cent of respondents reported experiencing a traumatic event, with over 30 per cent reporting four or more traumatic events:[195]

> 70.4% of respondents in 24 countries overall, and 82.7% of those in the United States, had experienced at least one type of traumatic event; in Canada, the prevalence is approximately 76% of adults (Van Ameringen et al., 2008). Exposure to traumatic events may cause post-traumatic stress disorder (PTSD), but also a range of other negative mental and physical health outcomes, impacts on daily living and coping, cognitive processes, and even neurobiological changes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The types of experiences that may be traumatic include, but are not limited to, accidents and injuries (e.g., natural disasters, car accidents), interpersonal violence (e.g., intimate partner violence, child maltreatment), collective violence (e.g., war, genocide, and the ongoing effects of colonialism), and others such as the death of a loved one (Benjet et al., 2016). Overall, trauma is a serious threat to individual health and well-being worldwide, and significant efforts are expended to understand, prevent, and address the problem (SAMHSA, 2014).[196]

[190] Blue Knot Foundation, 'Foundations for Building Trauma Awareness: Professional Development Training Booklet,' delivered 17 September 2021.
[191] Levenson, J. 'Trauma-Informed Social Work Practice,' 2017, *Social Work*, 62(2), p. 105-113, viewed 18 October 2021 <https://doi.org/10.1093/sw/swx001>.
[192] Henderson C and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 79.
[193] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[194] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[195] Benjet C, Bromet E and Karam E et al, 'The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium,' *Psychological Medicine*, 2016, 42(2), p.327-343.
[196] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.

According to the Blue Knot Foundation, 'one in four adult Australians experience trauma during childhood.'[197] The Australian Institute of Family Studies also identifies that 'exposure to adverse, potentially traumatic events in childhood is not uncommon,' highlighting the findings of the ACE study in identifying that, of 17,337 respondents, 64 per cent had experienced at least one adverse experience and approximately 12 per cent had experienced four or more in the first 18 years of life.[198]

The Personal Safety Survey (**PSS**) undertaken by the ABS, provides statistics for family, domestic, sexual violence, physical assault, partner emotional abuse, child abuse, sexual harassment, stalking and safety in Australia. The 2016 PSS identified that:

- two in five Australian adults (39 per cent of Australians, or 7.2 million people) had experienced violence since the age of 15;
- one in six women (17 per cent of Australians, or 1.6 million people) and one in sixteen men (6.1 per cent of Australians, or 547,600 people) experienced partner violence since the age of 15;
- over one in 10 adult Australians (13 per cent, or 2.5 million people) experienced abuse as children under the age of 15. This includes an estimated 1.6 million people (8.5 per cent) who experienced physical abuse and 1.4 million (7.7 per cent) who experienced sexual abuse; and
- one in eight women (13 per cent, or 1.2 million people) and one in ten men (10 per cent, or 896,700 people) 'witnessed' violence towards their mother by a partner before the age of 15.[199]

The AIHW identifies that family, domestic, and sexual violence is 'a major health and welfare issue. It occurs across all ages, and all socioeconomic and demographic groups, but predominantly affects women and children,' and can inflict physical injury, psychological trauma, and emotional suffering … [lasting] a lifetime and can affect future generations.'[200]

6.1.10 Not all individuals exposed to potentially traumatic events experience trauma

Responses to traumatic experiences 'vary widely, with not all exposure leading to negative outcomes. It is the individual response to the experience that determines whether it is considered traumatic or not.'[201]

To understand the concept of trauma, researchers identify that a distinction needs to be made between event/s and a person's reaction to the event/s,[202] explaining that 'some individuals experience traumatic events and go on with their lives without lasting effects while others have more difficulty and experience ongoing traumatic stress reactions:'[203]

[197] Blue Knot Foundation, 'Breaking Free,' Blue Knot Foundation, Milsons Point, September 2019, p. 12.
[198] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[199] Australian Bureau of Statistics, 'Personal Safety, Australia,' ABS, Canberra, 2017, viewed 21 October 2021 <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release#experience-of-abuse-before-the-age-of-15>.
[200] Australian Institute of Health and Welfare, *Family, domestic, and sexual violence in Australia: 2018*, Australian Government, Canberra, 2018, p. vi.
[201] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 6.
[202] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.
[203] Ferrara N, *In Pursuit of Impact: Trauma- and Resilience-Informed Policy Development*, 2018, Lexington Books, Lanham, p. 13.

> While life-threatening events are clearly traumatic, overwhelming stress can also occur in the absence of direct threats to survival…
>
> It is important to note the role of *perception*. Trauma is determined from the perception of threat rather than by the magnitude of the event/s. This means that it can arise from seemingly minor 'triggers'. This important point has many implications…
>
> The role of perception reveals why contrasting experiences can be traumatic, and why some experiences may be traumatic for some people and not for others.[204]

An individual's experience and perception of a particular event 'determines whether it is traumatic or not,' and how an event is experienced may be linked to a range of factors including the individuals' cultural beliefs, availability of social supports, or the developmental stage of the individual: [205]

> Not all children or adults who are exposed to potentially traumatic events experience long-term health problems. This may be due to protective factors, which help shield individuals from the lasting effects of trauma. Protective factors include: parental knowledge of child development; healthy parent-child attachment; social connections; and social and emotional competence.[206]

6.1.11 Services can unintentionally re-traumatise individuals

Researchers identify a broad consensus that 'many consumers who engage with public, private and community managed mental health and human services are trauma survivors,' with 'trauma experiences shape[ing] their responses to service providers:'[207]

> People impacted by trauma characteristically present to multiple services over a long period of time and care is often fragmented with inadequate coordination between services, and poor referral pathways and follow-up protocols which results in a 'merry go round' of unintegrated care. This risks retraumatisation and compounding problems as a result of unrecognised trauma. Such escalation and entrenchment of symptoms is psychologically, financially and systemically costly. Understanding that trauma underpins the way in which many people present who attend a diversity of service settings necessitates substantially new ways of operating.[208]

[204] Kezelman, C. and Stavropoulos, P. *Talking about Trauma: Guide to conversations and screening for health and other service providers,* Blue Knot Foundation, Milsons Point, 2018, p. 7.
[205] Ferrara N, *In Pursuit of Impact: Trauma- and Resilience-Informed Policy Development*, 2018, Lexington Books, Lanham, p. 13. Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 8.
[206] Centre for Health Care Strategies Inc. 'Understanding the Effects of Trauma on Health,' CHCS, Hamilton, 2017, viewed 19 October 2021 <https://www.chcs.org/media/Fact-Sheet-Understanding-Effects-of-Trauma-1.pdf>.
[207] Bateman K, Henderson C, and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, Mental Health Coordinating Council and Adults Surviving Child Abuse, Sydney, p. 1.
[208] Bateman K, Henderson C, and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, Mental Health Coordinating Council and Adults Surviving Child Abuse, Sydney, p. 1.

Research also highlights that systemic responses to trauma and its effects provided by 'public institutions and service[s] … intended to provide services and supports to individuals are often themselves trauma-inducing.'[209] Services may retraumatise a people as a result of:

- society which continues to ignore abuse and minimise its effects; which pathologises and blames the victim rather than providing informed support; [and]
- use of coercive interventions (e.g., seclusion and restraint, forced involuntary medication practices), and philosophies of care based on control and containment rather than empowerment and choice. The result is often unintentional retraumatisation in already vulnerable populations.[210]

The New South Wales Mental Health Coordinating Council identifies that 'trauma survivors often experience services as unsafe, disempowering and/or invalidating' and may withdraw from seeking support, particularly when services fail to understand how their past trauma has shaped their 'behaviours and reactions … and the way people approach potentially helpful relationships.'[211]

The challenges faced by Individuals experiencing trauma can be 'exacerbated' by responses received from human service sectors,[212] with the United States' Substance Abuse and Mental Health Services Administration (**SAMHSA**) and the Blue Knot Foundation identifying that many public institutions can be re-traumatising:[213]

> While confronting to contemplate, the re-traumatisation of already traumatised people by and within diverse services of the health sector is highly prevalent. Research establishes that service practices which lead to retraumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched. In fact research which supports this disturbing claim is growing. Recognition of the reality that `[t]rauma has often occurred in the service context itself' is a major impetus for introduction of `trauma-informed' practice.'[214]

How services are provided 'can have important impacts on health and well-being,' particularly for individuals experiencing trauma. 'When serving survivors of trauma and violence, a lack of understanding of the complex and lasting impacts of these experiences may lead to harm and to missed opportunities to provide effective care.'[215]

[209] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[210] Bateman K, Henderson C, and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, Mental Health Coordinating Council and Adults Surviving Child Abuse, Sydney, p. 3.
[211] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[212] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 24
[213] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 3.
[214] Kezelman, K. and Stavropoulos, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* Blue Knot Foundation (formerly Adults Surviving Child Abuse), NSW, 2012, p. 86.
[215] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.

6.2 Trauma informed approaches to service provision

There is a diverse and 'rapidly growing research base leading to new understanding of trauma and new possibilities for recovery from it. Correspondingly, it also has major implications for service-provision:'[216]

> Research has established that trauma is a major public health problem. Yet within current systems it is frequently unrecognised, unacknowledged, and unaddressed. Many of those affected have been inadvertently re-traumatised in systems of care lacking the requisite knowledge and training around the particular sensitivities, vulnerabilities and triggers of trauma survivors.[217]

In recognition of the prevalence, impacts, and growing awareness of trauma, there has been increased attention to the concept of **trauma informed approaches** 'to help services attend to the effects of trauma, and its links to health and behaviour, so as to create safe spaces that limit the potential for further harm.'[218]

Fundamentally, trauma informed approaches involve 'a paradigm shift in service delivery culture to acknowledge and clearly articulate the importance of trauma in understanding and responding to client presentation.'[219]

6.2.1 Trauma informed approaches or services are distinct from trauma specific clinical interventions

Researchers identify that trauma informed interventions 'occur at two levels: trauma-specific interventions and trauma informed models of care.' [220]

Trauma specific clinical interventions 'refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma.'[221] Trauma specific interventions include diagnostic and treatment services 'designed to treat the actual sequelae of sexual or physical abuse trauma … [such as] grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help make to render painful images more tolerable, and behavioural therapies which teach skills for the modulation of powerful emotions.'[222]

Trauma informed approaches or services 'do not directly treat trauma or the range of symptoms with which its different manifestations are associated,' however, they are 'informed about, and sensitive to, trauma related issues' and incorporate key trauma principles into organisational care.[223]

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[216] Kezelman, K. and Stavropoulos, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* Blue Knot Foundation (formerly Adults Surviving Child Abuse), NSW, 2012, p. xxx.
[217] Kezelman, C. 'Trauma informed practice,' *Mental Health Australia*, Deakin, 2014, viewed 26 October 2021 <https://mhaustralia.org/general/trauma-informed-practice>.
[218] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.
[219] Wall, L. Higgins, D. and Hunter, C., *Trauma-informed care in child/family welfare services*, Australian Institute of Family Studies, Melbourne, 2016, p. 12.
[220] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 4.
[221] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 4.
[222] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15-16, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[223] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, Blue Knot Foundation, NSW, p. 88; Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, p. 9.

> A 'trauma informed' system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services. A 'trauma informed' system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in 'traumatology'.[224]

Researchers identify that the provision of both trauma specific clinical interventions and trauma informed approaches are essential in addressing the consequences of trauma, noting that 'the provision of trauma informed services must also be supported by trauma specific services, which provide specific interventions to address the consequences of trauma.'[225] Similarly, trauma specific services require a trauma informed 'environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services.'[226]

The Office's focus on trauma informed approaches relates to the broader organisational or service system responses that are **trauma informed**, rather than trauma specific clinical interventions. However, growing awareness of trauma and its impacts have led to calls from researchers for the need for both trauma informed and trauma specific services.[227]

6.2.2 Understanding trauma informed approaches to service provision

Trauma informed approaches describe a framework for human service delivery that is 'based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.'[228]

The research literature identifies that trauma informed approaches aim to 'normalise symptoms and behaviours that have traditionally been pathologized,' with the approach asking 'what has happened to you?' rather than, 'what is wrong with you?'[229]

[224] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[225] Kezelman C, 'Trauma informed practice,' *Mental Health Australia*, 2014, viewed 26 October 2021 <https://mhaustralia.org/general/trauma-informed-practice>.
[226] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[227] Fallot R and Harris M, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2009, Community Connections, Washington DC, p. 2.
[228] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[229] Queensland Government, *Trauma-Informed Care and Practice: A guide to working well with Aboriginal and Torres Strait Islander Peoples*, State of Queensland, Brisbane, 2019, p. 3.

Internationally and in Australia, researchers have undertaken significant work in conceptualising and articulating trauma informed approaches to service provision. A central theme underpinning this work is the principle that 'recognition of trauma is core to accommodating the service needs of service survivors:'[230]

> Trauma-Informed Care and Practice (TICP) is an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics … TICP is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services.[231]

SAMHSA has examined and articulated the concept of trauma and trauma informed approaches, identifying that trauma informed approaches are grounded in a set of four 'R's' or key assumptions:

> A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**.[232] [original emphasis]

The Blue Knot Foundation has identified that trauma informed services:

- attune to the possibility of trauma in the lives of everyone seeking support
- apply the core principles of safety, trustworthiness, choice, collaboration and empowerment (Fallot and Harris, 2001)
- accommodate the vulnerabilities of trauma survivors including people from diverse backgrounds
- minimise the risks of re-traumatisation and promote healing
- emphasise physical and emotional safety for everyone
- recognise coping strategies as attempts to cope
- collaborate with clients, and affirm their strengths and resources
- recognise the importance of respect, dignity and hope
- focus on the whole context in which a service is provided and not just on what is provided.[233]

[230] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 29.
[231] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 9.
[232] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 9.
[233] Blue Knot Foundation, 'Building a Trauma-Informed World,' Blue Knot Foundation, Milsons Point, 2021, viewed 4 November 2021 <https://blueknot.org.au/resources/building-a-trauma-informed-world/>.

6.2.3 Key principles of trauma informed approaches

Frameworks articulating trauma informed approaches to service provision identify a set of key principles underpinning these approaches. 'Although at times there might be subtle variations in terminology, and a degree of overlap between the principles, there is general congruence' around five key principles of trauma informed approaches.[234] These principles include:

SAFETY — **Ensuring physical and emotional safety**

Trauma informed approaches promote safety by:

- recognising the social, interpersonal, personal and environmental dimensions of safety. Understanding safety as defined by those served is a high priority;
- establishing a safe physical, psychological and emotional setting where basic needs are met for staff and the people they serve;
- ensuring staff are attentive to signs of consumer discomfort or unease, and understand these signs in a trauma informed way; and
- provider responses are consistent, predictable, and respectful.

TRUSTWORTHINESS — **Maximising trustworthiness through task clarity, consistency, and interpersonal boundaries**

Trauma informed approaches maximise trustworthiness by:

- providing clear information about what will be done, by whom, when, and why;
- maintaining appropriate boundaries; and
- conducting organisational operations and making decisions with transparency, and with the goal of building and maintaining trust.

CHOICE — **Maximising consumer choice and control**

Trauma informed approaches maximise choice and support autonomy through:

- ascertaining how much choice a consumer has over what services they receive;
- ensuring consumers get a clear and appropriate message about their rights and responsibilities;
- building in choices that make a difference to consumer-survivors (e.g. 'when would you like me to call?' 'Is there some other way you would like me to reach you or would you prefer to get in touch with me?');

[234] Smith, P. and Kaleveld, L. *Addressing Trauma in Western Australia*, Western Australian Association for Mental Health, Perth, 2020, p. 24.

- understanding the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice;
- supporting clients in cultivating self-advocacy skills; and
- empowering staff to do their work as well as possible with adequate organisational support and in an environment in which they also feel safe.

COLLABORATION **Maximising collaboration and sharing power**

Trauma informed approaches:

- place importance on partnering and the leveling of power differences between staff and clients, and among organisational staff;
- promote collaborative, strengths-based practice that values the person's expertise and judgement,
- demonstrate that healing happens in relationships and in the meaningful sharing of power and decision-making;
- cultivate a model of doing 'with' rather than 'to' or 'for'; and
- build a significant role for consumers in the planning and evaluation of an agency's services.

EMPOWERMENT **Prioritising empowerment and skill building**

Trauma informed approaches foster empowerment by:

- recognising and building upon an individuals' strengths and experiences;
- understanding that recovery is possible for everyone, regardless of how vulnerable they appear and instilling hope by establishing future oriented goals;
- providing opportunities for consumer and former consumer involvement in the planning and evaluation of services; and
- fostering a belief in the primacy of the people served, in resilience, and in the ability of individuals, organisations, and communities to heal and promote recover from trauma.[235]

[235] Adapted by Ombudsman Western Australia, from: Fallot R and Harris M, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2009, Community Connections, Washington DC, p. 7-10.; Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 8; Kezelman, C. Stavropoulos, P, *Talking About Trauma: Guide to Everyday Conversations for the General Public*, 2017, p. 12-23; and Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 11.

6.2.4 Trauma and violence informed approaches acknowledge the impact of systemic inequalities and violence

In acknowledging that violence and abuse occurs within broader structural systems and inequalities, researchers have identified that frameworks for trauma and violence informed approaches 'expand the concept of trauma informed practice to account for the impact of systemic and interpersonal violence and inequalities have on a person's life.'[236]

> **Trauma-informed care (TIC)** creates safety for service users by understanding the effects of trauma, and its close links to health and behaviour; it is not about eliciting or treating people's trauma.
>
> **Trauma- and violence-informed care (TVIC)** expands on this to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life, emphasizing both historical and ongoing violence and their traumatic impacts. It shifts the focus to a person's experiences of past and current violence so problems are seen as residing in both their psychological state, and social circumstances.[237]

Researchers identify that in expanding the concept of a trauma informed approach, trauma and violence informed approaches bring into focus 'both historical and ongoing interpersonal violence and their traumatic impacts and helps to emphasize a person's experiences of past and current violence so that problems are not seen as residing only in their psychological state,' but also 'in social circumstances.'[238]

Principles underpinning trauma and violence informed approaches are similar to those principles identified for trauma informed approaches. These principles include an 'understanding of trauma and violence,' the creation of 'emotionally and physically safe environments for clients and service providers,' fostering opportunities for 'choice, collaboration, and connection,' and the provision of a 'strengths-based and capacity building approach to support client coping and resilience.'[239] In identifying the difference between trauma informed and trauma and violence informed approaches, researchers identify that the latter 'brings an explicit focus' to:

- broader structural and social conditions, to avoid seeing trauma as happening only "in people's minds"; e.g., discriminatory systems will break the bonds of trust that need to exist in a service context;
- ongoing violence including "institutional violence", i.e., policies and practices that perpetuate harm ("system-induced trauma"), e.g., making people retell their trauma to satisfy the needs of the system, rather than those of the person; [and]
- the responsibility of organizations and providers to shift services at the point of care supported by policies and systems that enable these shifts.[240]

[236] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.
[237] Wathen C and Varcoe C, *Trauma- & Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations & Providers*, 2021, Gender, Trauma & Violence Knowledge Incubator @ Western University and Equip Health Care, London, Canada, p. 1.
[238] Varcoe C, Wathen C, Ford-Gilboe M, et al, *A VEGA Briefing Note on Trauma-and Violence-Informed Care*, 2016, VEGA Project and PreVAil Research Network, Ontario, Canada, p. 1.
[239] Ponic P, Varcoe C and Smutylo T, *Trauma-(and Violence-) Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations: Victims of Crime Research Digest No. 9*, 2018, Department of Justice, Ottawa, viewed 8 November 2021, <https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html>.
[240] Varcoe C, Wathen C, Ford-Gilboe M, et al, *A VEGA Briefing Note on Trauma-and Violence-Informed Care*, 2016, VEGA Project and PreVAil Research Network, Ontario, Canada, p. 1.

The research literature highlights that this shift in language also allows for 'a more expansive understanding of people's experiences of violence and trauma,' as, particularly in the case of complex trauma, 'histories of violence typically include interconnected experiences of interpersonal and systemic violence.' Further, 'for many victims, interpersonal violence is ongoing; it can be intergenerational and linked to broader historical contexts.'[241]

6.2.5 Trauma informed, culturally strong healing approaches

The research literature highlights the importance of trauma informed approaches respecting diversity and ensuring cultural competency, identifying that a trauma informed approach 'understands how cultural context influences perception of and response to traumatic events and the recovery process,' and uses interventions respectful of and specific to cultural backgrounds,[242] leveraging the healing value of traditional cultural connections.[243]

In highlighting that trauma-informed approaches 'need to be responsive to cultural, historical, and gender issues,' researchers also highlight that this includes 'the provision of gender-responsive services, or considering gender-specific needs when interacting with individuals.'[244]

Select frameworks, such as SAMHSA's trauma informed approach, also include cultural, historical, and gender issues as a principle of trauma informed approaches. However, some researchers have identified that issues of 'culture and culturally sustaining practices' should instead be 'an overarching principle for which all other principles must be seen through.'[245]

In the Australian context, the Healing Foundation (the national Aboriginal and Torres Strait Islander organisation established to address the ongoing traumas of the Stolen Generations and forced childhood removals) has advocated for the adoption of trauma aware, healing informed approaches that:

> … emphasise the fundamental importance of collective healing processes grounded in Aboriginal and Torres Strait Islander cultures and perspectives, recognising the ongoing suffering of colonisation, the mass impacts of genocidal practices such as the Stolen Generations, and the realities of ongoing racism and interpersonal violence. According to the Healing Foundation: Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities.[246]

[241] Ponic P, Varcoe C and Smutylo T, *Trauma-(and Violence-) Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations: Victims of Crime Research Digest No. 9*, 2018, Department of Justice, Ottawa, viewed 8 November 2021, <https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html>.
[242] Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 8.
[243] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 11.
[244] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.
[245] Davis M, 'A Focus on the Trauma Informed Principle Cultural, Historical, and Gender Issues,' *Trauma Informed Oregon*, 30 July 2021, viewed 4 November 2021 <https://traumainformedoregon.org/a-focus-on-the-trauma-informed-principle-cultural-historical-and-gender-issues/>.
[246] Salter M, Conroy E, Dragiewicz M et al, *'A deep wound under my heart': Constructions of complex trauma and implications for women's wellbeing and safety from violence (Research Report, 12/2020),* 2020, ANROWS, citing Healing Foundation, *A resource for collective healing for members of the Stolen Generations*, 2014, <https://healingfoundation.org.au/resources/a-resourcefor-collective-healing-for-members-of-the-stolengenerations/>.

The Healing Foundation further identifies 'eight elements of a quality healing program'

1. Developed to address issues in the local community
2. Driven by local leadership
3. Have a developed evidence base and theory base
4. Combine western methodologies and Indigenous healing
5. Understand the impact of colonization and transgenerational trauma and grief
6. Build individual, family and community capacity
7. Proactive rather than reactive
8. Incorporate strong evaluation frameworks[247]

An example of a 'community centred, culturally strong, trauma-informed' framework for strengthening community capacity to end violence has been developed by the Ngaanyatjarra Pitjantjatjara Yankunytajatjara (**NPY**) Women's Council together with the Australian Childhood Foundation.[248] As noted by the Australian Human Rights Commission Report *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, this practice framework:

> … contains a strong commitment to resourcing communities with the tools to build and develop their own strategies based in their knowledge systems, stories, ceremonies, healing practices and spiritual beliefs to challenge violence and find safety in their lives.
>
> The Framework is useful in understanding what forms of working practices are considered trauma-informed and appropriate for Indigenous organisations to deliver.
>
> The Framework consists of eleven stages of actions and strategies which should be approached gradually and with care by practitioners in a linear order.
>
> Each stage of the Framework has a set of actions, strategies and practical information for the family violence practitioner to guide and evaluate their work.[249]

[247] Aboriginal and Torres Strait Islander Healing Foundation, *Healing Informed Organisations*, 2015, p. 11.
[248] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney p. 141.
[249] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney, p. 141-142.

The stages of the NPY Women's Council framework for strengthening community capacity to end violence are as follows:

Source: Australian Childhood Foundation and Ngaanyatjarra Pitjantjatjara Yankunytajatjara Women's Council[250]

6.2.6 Trauma informed approaches recognise trauma, but do not prevent it

However, some academics in the field of social work, feminism and activism have identified that, through employing biomedical and psychiatric constructions of trauma, this approach may avoid 'the social and political roots of a problem, the experiences and effects of oppression and shared forms of trauma.'[251] If conceptualised or used synonymously through a medical lens, such as through the narrow lens of post-traumatic stress disorder, such approaches risk 'individualising' constructions of trauma:[252]

> … which can blame and pathologise the individual rather than acknowledge and address the broader structural inequalities which cause trauma, such as colonisation and/or gender-based violence.[253]

Similarly, in developing guidelines for implementing trauma informed practice, Blue Knot Foundation President Dr Cathy Kezelman has identified 'a striking anomaly needs to be noted. Increased recognition of child abuse is not the same as effective and systematic addressing of it' as:

> … The challenges posed by trauma relating to child abuse are not, then, solely 'clinical', 'personal', 'psychological' or the preserve of 'the helping professions'. They are social, national and political in the broadest sense. Both because of its prevalence and ongoing effects, child abuse in its various forms comprises a major public health problem, and widespread recognition of this by policy-

[250] Tucci J, Lindeman J, Shilton M and Green L, Strengthening Community Capacity to End Violence: A Project for NPY Women's Council, 2017, Australian Childhood Foundation and NPY Women's Council Foundation, Alice Springs, p. 27.
[251] Mckenzie-Mohr, Coates & McLeod, 2011, p. 136, cited by Funston L, *In the Business of Trauma: An intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis]*, 2019, University of Sydney, Sydney Digital Theses, Sydney, p. 32.
[252] McKenzie-Mohr, S. Coates, J. and McLeod, H. 'Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention,' 2012, *Children and Youth Services Review,* 34(1), p. 136.
[253] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.

> makers, as well as by the public, comprises one of the major challenges that needs to be met.[254]

Trauma informed approaches offer a framework for better responding to the needs of those who have experienced trauma. However, trauma informed practice 'is ultimately not a violence prevention or social justice framework.'[255]

Literature concerning trauma informed approaches generally does not include 'explicit reference to social change, legislative change, social policy recommendations or community development strategies.'[256] In this context, researchers highlight that 'an orientation toward primary prevention must occur alongside secondary prevention efforts,' including trauma informed approaches.[257] These efforts require broader change.

6.3 Victims and witnesses of violent crime have diverse and varied needs for support

6.3.1 Our understanding of victims' needs has evolved in recent years

In recent years, a number of Australian reviews and inquiries have been conducted into the needs and experiences of victims. Most notably, these have included the Royal Commission into Institutional Responses to Child Sexual Abuse, and the Victorian Royal Commission into Family Violence. The reports of these inquiries have provided new perspectives on victims' experiences, support needs, and the re-traumatisation that can arise from inadequate systemic responses.

Accordingly, the evidence base on victims' needs and experiences has expanded in recent years, broadening understandings of victimisation and trauma beyond:

> … an understanding of crime as an isolated or confined experience from which victims of crime are well equipped to recover; that victims experience crime with few pre-existing issues; and that victims of crime are always able to identify and articulate what they need from the system.[258]

It is now well-recognised that victims of crime have diverse needs and experiences of victimisation, and may have multiple and/or complex support requirements – all of which occur in the broader context of their life circumstances, historical interactions with support services and pre-existing vulnerabilities, as noted in a 2020 review of Victoria's victim support services system:

- The way in which a person responds to the experience of victimisation can depend on personal factors - such as age, gender, abilities, health, ethnicity, culture, socioeconomic status, social networks and previous experiences and

[254] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 44.
[255] Funston, Leticia, *In the Business of Trauma: An intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis]*, University of Sydney, Sydney Digital Theses, p. 34.
[256] Funston L, *In the Business of Trauma: An intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis]*, 2019, University of Sydney, Sydney Digital Theses, p. 32, and McKenzie-Mohr, S. Coates, J. and McLeod, H. 'Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention,' 2012, *Children and Youth Services Review,* 34(1), p. 142.
[257] McKenzie-Mohr, S. Coates, J. and McLeod, H. 'Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention,' 2012, *Children and Youth Services Review,* 34(1), p. 142.
[258] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: Victim Services Review: Final Report*, November 2020, p. 12, viewed 27 May 2022, <https://cij.org.au/cms/wp-content/uploads/2020/11/strengthening-victorias-victim-support-system-victim-services-review-centre-for-innovative-justice-november-2020.pdf>.

interaction with the justice system; the type and seriousness of the crime; and the nature of the victim's relationship with the offender.

- Most people have an emotional reaction to victimisation, with increased stress and persisting psychological, social and physical effects associated with more serious or violent offences.

- Effects of victimisation can be wide-ranging – for example, the RCIRCSA [Royal Commission into Institutional Responses to Child Sexual Abuse] found that victims of child sexual abuse experienced impacts in multiple spheres, such as mental health, physical health, including substance misuse; interpersonal relationships, including difficulties with trust and intimacy; connection to culture, spirituality and religious involvement; sexual identity, gender identity and sexual behaviour; and education, employment and economic security.

- While the effects of property crimes are typically not as severe and long-lasting as violent personal crimes, victims of property crime can nevertheless suffer emotional, psychological and physical health effects, sometimes to a severe degree.

- Emerging crime types, such as online fraud, can have "a devastating impact on victims and their families". For example, victims of online fraud often experience significant emotional and psychological impacts, with feelings of shame, distress, sadness and anger often reported, as well as loss of trust in others. A 2016 Australian study reported that multiple online fraud victims indicated that they had seriously contemplated suicide as a result of their victimisation.

- Many victims of crime never report to police with under-reporting even more pronounced for specific cohorts and types of offences. For example, some studies indicate that as many as 90 per cent of Aboriginal women do not disclose experiences of violence.

- The effect of crime victimisation can compound, as well as be compounded by, pre-existing vulnerabilities in those already experiencing disadvantage or marginalisation, such as refugees, women escaping family violence, Aboriginal and Torres Strait Islander peoples, and people with disabilities.

- Prior experiences of victimisation – for example, childhood sexual abuse and childhood physical abuse – can be predictive of secondary victimisation, which in turn compounds and exacerbates the impact of crime in a multiplicative way.

- The link between victimisation and offending is one of the strongest empirical associations in criminological literature. A 2012 review of the literature on the 'victim-offender overlap' identified studies reporting that more than half of victims of crime become offenders and vice versa.

- The link between victimisation and offending can be even more pronounced for some crime types and cohorts. For example, a 2014 literature review of the profile and needs of incarcerated women noted high rates of histories of childhood victimisation (particularly sexual abuse) and subsequent victimisation as adolescents and adults (including sexual assault and family violence). Similarly, an Australian study found that victims of child sexual

> abuse were "almost five times more likely to be charged with an offence than their peers in the general population."[259]

6.3.2 Victims of violent crime want individualised information and support services that are proactive and trauma informed

Research into victims' experiences has also identified the diversity of victim support needs. The Royal Commission into Institutional Responses to Child Sexual Abuse highlighted that:

> At various times, depending on the circumstances, victims and survivors seek support from a range of mainstream and specialist services to help manage the detrimental impacts of abuse on their mental health. They may also need support for legal, education, housing, health, employment and financial issues, and for assistance with reporting abuse. The services used by victims and survivors span several sectors and can be difficult to navigate. The need for support often extends to secondary victims, such as family members, carers and friends and others ...[260]

Victims may require both practical supports and emotional or psychological supports, as highlighted by the Australian Institute of Criminology:

> For victims of violent crimes, it is frequently assumed that what is most needed is emotional and psychological support. However, an American study on female victims of violent crime indicated that practical support, such as the provision of daycare, housing, education, food and job training was regarded as being more helpful than the provision of emotional support from family and friends, professional counselling, medication, and support from self-help groups and medical providers. It is important to note that emotional support was not regarded as unhelpful, but rather that it was not as relevant to the practical needs of the victim. This result may reflect a misdirected emphasis on the provision of services to victims of violent crimes.
>
> A study sponsored by the National Institute of Justice in the United States concluded that service providers often fail to adequately address the more concrete/tangible needs of victims, focusing instead on providing emotional/psychological support. In addition, an Australian qualitative study suggested that the three most important aspects of providing support services for victims of domestic violence were that they remain free, anonymous and flexible, with the added component that that they address the longer term effects of the crime, as well as providing immediate crisis support. [references omitted][261]

[259] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: Victim Services Review: Final Report*, 2020, p. 21-23, viewed 27 May 2022, <https://cij.org.au/cms/wp-content/uploads/2020/11/strengthening-victorias-victim-support-system-victim-services-review-centre-for-innovative-justice-november-2020.pdf>.
[260] Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report Volume 9: Advocacy, support and therapeutic treatment services*, 15 December 2017, p. 9-10.
[261] McGregor K, Renshaw L, Andrevski H, *ACT Victims of Crime Referral Project: Final Report (AIC Reports Technical and Background Paper 55),* 2013, Australian Institute of Criminology, p. 9.

Qualitative research undertaken through interviews of victims of violent crime in Victoria identified several key themes relevant to improving victim support services in that State, including that:

> Victims of crime often cannot differentiate between the various services and agencies with which they interact in the aftermath of a crime. …
>
> Victims of crime need a timely response … Depending on the nature of the crime experienced, however, some had urgent needs that were not able to be addressed immediately. These often included practical and safety needs–- such as where a crime meant that a victim could not immediately return to their home or where the offender posed an ongoing risk. Other immediate needs included information and psychological first aid; taxi vouchers and transport; support to coordinate and attend medical appointments; and childcare. Where victims of crime were not able to work because of the crime, it was important to instigate rapid processes to access interim … payments or support through Centrelink. …
>
> Victims of crime want information provision that is individualised. …
>
> Victims of crime want support that is proactive and trauma-informed …
>
> Victims of crime want a single point of contact to help them navigate the system, although this did not always need to be an individual worker. Rather, they wanted to know that there was one 'place' which would provide them with the information which was relevant to them at the time; holistically assess and respond to their needs; and would not require them to re-tell their story. …
>
> Victims of crime want to know what is happening with their case …
>
> Victims of crime want support to navigate legal issues …
>
> Families [of victims of crime] are not well-supported … [and] there is a need, in some cases, to work with the whole family. This includes ongoing individual assessments of family members to understand the extent to which they may be impacted by their loved one's experience of victimisation over time.[262]

Victims of crime additionally face barriers to accessing appropriate services and care, including after the conclusion of court proceedings, parole applications and the period after an offender is released.[263] Some of these barriers include:

- that the evidence-base 'about the effectiveness of support interventions … [in] successful[y] meeting victims' needs' is limited, and still developing;[264]
- victims are often in need of 'the missing middle in social services,' not often meeting the acute clinical service criteria for entry into public mental health services;[265]
- a 'shortage' in appropriately qualified mental health professionals;[266] and

[262] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: Victim Services Review: Final Report*, 2020, p. 32-41,
[263] Department of Justice, *A report on the statutory review of the Victims of Crime Act 1994 (WA)*, Government of Western Australia, May 2021, p. 27.
[264] Ministry of Justice (UK), *Evidence and Practice Review of support for victims and outcome* measurement, November 2021, NatCen Social Research, p. iii.
[265] Craven R, 'The missing middle in social services, *The Mandarin*, 31 January 2020, <https://www.themandarin.com.au/124281-the-missing-middle-in-social-services/>; Orygen, *Defining the missing middle*, <https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle/orygen-defining-the-missing-middle-pdf?ext=>.
[266] Institute for Social Science Research, *Final Report: National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*, 2020, The University of Queensland, p. 7, 16, 22, 43.

- victims' vulnerability to further re-victimisation when accessing services provided by organisations that are outside the scheme of regulation and oversight provided 'unregulated private health facilities … not covered by the definition of "Health Service" or "Hospital" in the *Private Hospitals and Health Services Act 1927*' which are currently the subject of the Education and Health Standing Committee Inquiry into the Esther Foundation and unregulated private health facilities.[267]

6.4 Vicarious trauma

6.4.1 Workers providing services to people who have experienced trauma may experience 'vicarious trauma'

> The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.[268]

Researchers identify that workers supporting survivors of trauma are 'at risk of being negatively impacted' by their work.[269] The changes a person may experience after routinely and repeatedly being exposed to first-hand or secondary trauma in the course of their employment, are referred to as 'vicarious trauma'.[270]

> [Vicarious trauma] … is related to concepts such as 'emotional exhaustion', 'burnout', 'compassion fatigue', 'secondary traumatisation' and 'counter-transference', but some key differences exist between some of these concepts. It can also be expressed as 'feeling heavy', or when the work (or an aspect of the work) 'gets inside you'.[271]

> Vicarious trauma is a cumulative effect of working with trauma, which can affect many aspects of a person's life. It may consist of short-term reactions, or longer-term effects that continue long after the work has finished. … some effects of vicarious traumatisation parallel those experienced by the primary victim/survivor.[272]

The research literature identifies that those who work to support others with trauma can experience a range of detrimental effects over time, including changes in the way they perceive the world:

[267] Legislative Assembly, Education and Health Standing Committee, Parliament of Western Australia, *Inquiry into the Esther Foundation and unregulated private health facilities: Terms of Reference*, 7 April 2022.
[268] Remen R, *Kitchen Table Wisdom: Stories that Heal*, 1996, Penguin, New York, cited by Dixon ,. 'When Compassion Hurts: An Introduction to Vicarious Trauma and Resilience,' NSW Health Youth Forum Presentations, 2019, p. 1.
[269] Office for Victims of Crime, *What is Vicarious Trauma*, 2021, viewed 22 October 2021 <https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma>.
[270] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 1.
[271] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 2.
[272] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 2.

> Connected to these experiences, vicarious traumatisation may also involve a change in a person's beliefs about themselves, the world, and other people within it. This is known in the psychological field as changes in their 'cognitive schema', and may involve:
>
> - feeling that the world is no longer a 'safe place' (for themselves and/or others);
> - feeling helpless in regard to taking care of themselves or others;
> - feeling their personal freedom is limited; and
> - feelings of alienation (that their work within the field of sexual assault sets them apart from others).[273]

Vicarious trauma can arise in response to a number of high stress professions, including among first responders working in policing, paramedic, fire and other emergency services; social workers; mental health professionals; victim support workers; child protection workers; lawyers and paralegal staff; and others working during war and natural disasters.[274]

Research has shown that professionals working with survivors of childhood abuse and other forms of interpersonal violence produce the highest scores of 'traumatic stress' and may experience a higher level of 'disrupted beliefs'.[275]

Vicarious trauma can also be experienced by researchers working 'on topics that are permeated with trauma,' fatality review jurisdiction staff, criminologists and others whose work requires 'empathetically reviewing stories of profound loss and trauma and … the worst of humankind.'[276]

Vicarious trauma research points out that these responses are normal human reactions to circumstances involving repeat exposure to distressing events. Further, researchers note that those who experience vicarious trauma should not be 'pathologised' or 'viewed … as medically or psychologically abnormal'.[277]

[273] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3.
[274] Barrratt P, Stephens L, and Palmer M, *When Helping Hurts: PTSD in First Responders*, 2018, p. 5; Dixon A, 'When Compassion Hurts: An Introduction to Vicarious Trauma and Resilience,' 2019, NSW Health Youth Forum Presentations, p. 3. and Office for Victims of Crime, *Introduction to Vicarious Trauma for Law Enforcement*, 2021, Department of Justice, Office of Justice Programs, Washington.
[275] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3.
[276] National Center for Fatality Review and Prevention, *Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma*, 2016, p. 4; Moran R and Asquith N 'Understanding the vicarious trauma and emotional labour of criminological research,' *The Emotion and Emotional Labour of Criminological Researchers*, 2020 13 (2).
[277] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3; Henderson C, Everett M, and Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, Mental Health Coordinating Council, p. 10-11.

6.4.2 Organisations can support and protect their staff against vicarious trauma or increase the risk of its occurrence

Whilst exposure to trauma is 'the clearest predictor' of vicarious traumatisation, research highlights that caseloads (i.e. the extent of trauma exposure), are also predictive of the likelihood of vicarious trauma occurring in a workplace.[278]

Researchers identify that the culture in which work is undertaken is important in determining whether and how individuals experience vicarious trauma:

> Research shows that when the possibility of vicarious trauma is not recognised or acknowledged, people may be more detrimentally affected because there are few if any efforts to prevent or reduce this harm …
>
> "The values and culture of an organisation set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally." (Bell et al., 2003, p. 466)
>
> … An organisational culture that normalises the effects of working with trauma can be a start to providing a supportive environment for workers to address those effects in their work and wider lives. It may also give 'permission' or encouragement for workers to take care of themselves.[279]

In exploring how vicarious trauma can be mitigated or addressed, researchers identify that organisational approaches are crucial, and that 'emphasising individual coping strategies or "resilience"' should be avoided as they 'could be a form of "victim-blaming"' and misunderstand the causes of vicarious trauma:[280]

> As mental health professionals dedicated to the fair and compassionate treatment of victims in society, we have been strong in vocalizing concerns that those who are abused and battered not be blamed for their victimization and their subsequent traumatic response. Yet when addressing the distress of colleagues, we have focused on the use of individual coping strategies, implying that those who feel traumatized may not be balancing life and work adequately and may not be making effective use of leisure, selfcare, or supervision … In light of findings that the primary predictor of trauma scores is hours per week spent working with traumatized people, the solution seems more structural than individual. (Bober & Regehr, 2006, p. 8).[281]

Research highlights that organisations can create a supportive environment for individuals working in fields that routinely involve exposure to trauma, people affected by trauma, and traumatic material.

[278] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 5.
[279] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3, 8-10.
[280] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 7.
[281] Bober and Regehr, 2016, p. 8 cited by Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 7.

Researchers and stakeholders in the sexual assault and fatality review fields identify ways in which organisations can create a supportive environment for professionals in these fields. These may also be relevant to the diverse areas in which people work with individuals who have experienced trauma, and their stories. These include:

- **increased knowledge about vicarious trauma:** identifying and understanding vicarious trauma and related reactions, identifying and cultivating expertise, and sharing this knowledge and opening dialogue about vicarious trauma;
- **ensuring appropriate and diverse caseloads**: given that the level of exposure to trauma is a predictor of vicarious traumatisation levels, the number of cases workers see within a given time period needs to be appropriate;
- **providing effective supervision for all**: effective supervision is said to be an essential component of the prevention and healing of vicarious traumatisation. Responsible supervision creates a relationship in which a worker feels safe to express their fears, concerns and feelings of inadequacy;
- **access to debriefing**: debriefing and peer support were identified in a study of domestic violence counsellors as the most important strategy for dealing with the after-effects of a difficult counselling session;
- **staff and peer support**: the literature on both vicarious traumatisation and burnout emphasises the importance of social support within the organisation. Maintaining collegiality and avoiding social isolation is fundamental for workers; and
- **safety and comfort in the work environment**: being threatened by a client or other person at work is strongly correlated with compassion fatigue. As well as safety issues, workers' comfort is also important.[282]

6.4.3 People working with and witnessing the strength of trauma survivors, workers may experience 'vicarious resilience'

Just as individuals affected by trauma display resilience and strength, the witnessing of clients 'overcoming adversity and demonstrating an immense capacity to heal' can have a positive effect on people working with individuals affected by trauma.[283]

Vicarious resilience is embedded in resilience theory and is described as 'the growth that helping professionals experience through witnessing the experiences and triumphs of victims under adverse circumstances.'[284] It is a strength-focused concept that originated with therapists working with trauma victims:

> They noticed that among the psychotherapists working with torture survivors, some made specific reference to the inspiration and strength they drew from working with clients.[285]

[282] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 8-10, and National Center for Fatality Review and Prevention, *Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma*, 2016, Okemos, p. 7-8.
[283] Blue Knot Foundation, 'Managing Wellbeing and Recognising Vicarious Trauma: Professional Development Training Booklet,' 2021, p. 15.
[284] Jun J, 'Vicarious Resilience: Cultivating Internal Strength Through External Support,' *American Journal of Nursing*, 2020, 120(11), p. 13.
[285] Hernandez-Wolfe P, 'Vicarious Resilience: A Comprehensive Review,' *Revista de Estudios Sociales*, 2018, 66, 9-17, p. 10, doi: 10.7440/res66.2018.02.

Qualitative research studies have documented the presence of vicarious resilience in working with professionals who work with survivors and family members of those who have experienced severe trauma. This research has identified a number of positive factors associated with working with survivors, including 'changes in life goals and perspective, client-inspired hope, increased recognition of clients' spirituality as a therapeutic resource, increased capacity for resourcefulness, increased self-awareness and self-care practices, increased consciousness about power and privilege relative to clients' social location, and increased capacity for remaining present while listening to trauma narratives.'[286]

Working in fields that frequently interact with trauma survivors or traumatic experiences 'can mean making a positive and lasting impact' on issues of profound importance.[287] Vicarious resilience 'does not ignore the important phenomenon of compassion fatigue,' burnout, or vicarious trauma; 'instead, it offers a counterbalance, a positive resource to be attended to and nurtured.'[288]

6.5 Western Australian strategic frameworks identify the need for trauma informed approaches to service provision

Key Western Australian strategy documents in the area of suicide prevention, family and domestic violence, engaging with young people, empowering Aboriginal and/or Torres Strait Islanders, and workforce development recognise the significance of trauma and its impact upon individuals and communities. These strategy instruments also emphasise the need for services to adequately understand and appropriately respond to trauma.

6.5.1 *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* identifies that Western Australian responses to family and domestic violence will be trauma informed

Path to Safety sets out a whole-of-government and community plan for reducing and responding to family and domestic violence. Path to Safety highlights a series of guiding principles, including that 'effective solutions are locally tailored, culturally safe, and **trauma-informed**:'[289]

> All Strategy initiatives will maintain a focus on responding to people's diverse and intersecting experiences, providing-trauma informed supports, and supporting effective, local solutions.[290]

Similar to actions set out nationally in *Australia's National Plan to Reduce Violence against Women and their Children 2010-2022* and its Fourth Action Plan, Path to Safety also highlights trauma informed service provision for victims and perpetrators of family and domestic violence:

[286] Killian K, Engstrom D and Hernandez-Wolfe P et al, 'Development of the Vicarious Resilience Scale (VRS): A Measure of Positive Effects of Working With Trauma Survivors,' *Psychological Trauma: Theory, Research, Practice, and Policy*, 2017, 9(1), p. 23.
[287] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 11.
[288] Jun J, 'Vicarious Resilience: Cultivating Internal Strength Through External Support,' *American Journal of Nursing*, 2020, 120(11), p.13.
[289] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth, p. 6.
[290] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth, p. 25.

> To create safety for women and children, and to support them to recover and thrive, we will grow the capacity of earlier intervention and crisis response services to …
>
> - Deliver services that are person-centred, risk and trauma informed and accessible.[291]

With regard to perpetrator accountability and behaviour change, Path to Safety identifies that:

> Over the life of the strategy we will build an effective web of accountability through increased collaboration between services and agencies, streamlined responses and routine exchanges of risk relevant information, mechanisms to identify episodes of family and domestic violence and enact consequences for the perpetrator and pathways to suitable interventions …
>
> This will be underpinned by ensuring that service options for perpetrators also recognise and respond to the impacts of trauma.[292]

6.5.2 The WA Suicide Prevention Framework specifies the need for trauma informed supports

The WA Suicide Prevention Framework identifies that 'persons who have experienced abuse [or] trauma' are vulnerable populations 'who have been identified as having a higher risk of suicide and suicidal behaviour as a result of barriers they may experience due to social, economic, cultural, geographical, environmental and individual factors.'[293] Acknowledging the role of 'addressing historical and current trauma and the social determinants of health have in suicide prevention,'[294] the WA Suicide Prevention Framework identifies that:

> Action on suicide prevention is more effective when integrated with broad responses to the social and cultural determinants of poor health and wellbeing. This includes childhood trauma, family violence, poverty, insecure housing, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug use. For Aboriginal people the impact of colonisation and systemic racism also needs to be acknowledged.[295]

The WA Suicide Prevention Framework identifies that 'competent and confident assistance for people who are suicidal' is a priority under the framework, and highlights that 'embedding culturally secure, trauma-informed and compassionate procedures and responses into [Emergency Departments] as well as crisis and support services' are activities required to achieve this priority.[296]

[291] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, p. 35.
[292] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, p. 40.
[293] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 6-7.
[294] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[295] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[296] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 31.

With regard to Aboriginal and Torres Strait Islander people, the WA Suicide Prevention Strategy identifies a series of activities that 'aim to support the healing and restoration to wellbeing and mental health, both individually and collectively for Aboriginal people.' In addition to facilitating the development of 'a Western Australian Aboriginal Suicide Prevention Strategy prioritising a culturally secure [social and emotional well-being] approach to suicide prevention with dedicated regional plans,'[297] the WA Suicide Prevention Strategy highlights the following recommended activity:

> 11.7 Embed culturally secure, trauma-informed and compassionate procedures and responses into crisis and support services.[298]

6.5.3 *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025* identifies that services to young people must be trauma informed, and emphasises the need for all staff delivering services to young people are appropriately trained

In December 2020, the Mental Health Commission released the *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025* (**YPPA**), guiding the 'State Government, the Mental Health Commission and other agencies, the mental health and AOD [alcohol and other drugs] sector, and other stakeholders across the community, in supporting and responding to the mental health and AOD needs of young people aged 12 to 24 years.'[299]

In highlighting the contribution of stakeholders to YPPA, the Mental Health Commission identified:

> "Distress is a natural response to interpersonal adversity (e.g. abuse and trauma), young people don't have the agency to address or deal with this"
>
> Understanding and addressing trauma, and providing trauma informed care is important in preventing the emergence and/or increase in severity of mental health issues.[300]

YPPA identifies that young people with mental health and/or alcohol and other drug issues, and young people in general, 'come into contact with many different sectors and services, including AOD, mental health, health, justice, community, education and social service sectors:'[301]

> This intersectional relationship between sectors means that coordinated approaches for young people are critical and most effective. Services need to be trauma informed, so they can respond appropriately, particularly regarding trauma experienced by young people throughout their childhood.[302]

[297] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 37-38.
[298] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 38.
[299] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020.
[300] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 20.
[301] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 36.
[302] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 36.

YPPA emphasises the need to ensure that staff (including those outside the mental health and AOD sector),[303] are trained in delivering appropriate services to young people, highlighting that 'staff training in recovery oriented and trauma-informed care is crucial.'[304] YPPA further highlights 'trauma-informed training,' expanding 'delivery of trauma-informed care and practice training in the mental health community sector and to human services agencies' as an area for immediate action.[305]

6.5.4 Western Australia's *Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025* identifies that implementation of trauma informed care is necessary across health and human service systems, not just within mental health and alcohol and other drug settings

The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* identifies the requirement to develop a comprehensive mental health, alcohol and other drug workforce planning and development strategy. Western Australia's *Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2020-2025* (**the Workforce Strategic Framework**) 'aims to guide the growth and development of an appropriately qualified and skilled workforce that will provide individualised, high quality mental health and [alcohol and other drugs] services, and programs for the Western Australian community.'[306]

The Workforce Strategic Framework identifies that 'trauma-informed care' is an 'approach which recognises and acknowledges trauma and its prevalence amongst people using and delivering services, alongside awareness and sensitivity to its dynamics, in all aspects of service delivery, in order to prevent further trauma and support healing.'[307]

The Workforce Strategic Framework identifies nine principles that underpin the framework. Principle seven of the Workforce Strategic Framework relates to trauma informed care:

> **Trauma-informed and family-inclusive methods are common practice.**
>
> Implementation of trauma-informed care is necessary across health and human service systems, not just within mental health and AOD settings.
>
> **Trauma-informed care:** recognises that past trauma experiences affect a person's present perspectives and responses. Trauma-informed approaches commit to and act upon core principles of safety, trustworthiness, choice, collaboration and empowerment.

[303] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 43.
[304] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 42.
[305] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 43.
[306] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, p. 5.
[307] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, 2020, p. 48.

Trauma-informed services:

- are informed about, and sensitive to, trauma related issues;
- are attuned to the possibility of trauma in the lives of all clients;
- commit to and act on the core principles of safety, trustworthiness, choice, collaboration and empowerment;
- emphasise physical and emotional safety for all – clients, practitioners and service providers; and
- collaborate with clients, and affirm their strengths and resources; and recognise the importance of respect, information, hope and possibilities for connection.[308]

6.5.5 Health Service Providers have begun implementing a trauma informed approach, including through the *Western Australian Women's Health and Wellbeing Policy*; *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024* and *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*

The Department of Health developed the *WA Women's Health and Wellbeing Policy* 'to demonstrate the WA health system's commitment towards achieving the shared vision and strategic priorities of the *National Women's Health Strategy 2020 – 2030*'.[309] Included as a priority in the policy is 'the delivery of safe, trauma informed services for women experiencing gender-based violence'. [310] The Policy 'aims to drive continuous improvement in the health, safety and wellbeing of women and girls in WA' and:

> … is an initiating document to guide the development of new policies, programs, research, and service planning and delivery to drive equitable, accessible and appropriate services … [and recommends] 'that the WA Department of Health, Health Service Providers and health services develop implementation plans to deliver the recommended actions of the Policy …[311]

The *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024* aims to 'strengthen the integration of mental health care within all regional health services' … and:

> … aligns with the *WACHS Strategic Plan 2019–24* priorities of addressing disadvantage and inequity, building healthy and thriving communities in collaboration with our partners, and providing a safe and secure workplace.[312]

Additionally, the *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024* acknowledges the 'people who have experienced complex trauma' as a vulnerable group in country Western Australia and defines 'trauma-informed care' as follows:

[308] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, 2020, p. 29.
[309] Health Networks, Department of Health, *WA Women's Health and Wellbeing Policy*, 2019, Government of Western Australia.
[310] Health Networks, Department of Health, *WA Women's Health and Wellbeing Policy*, 2019, Government of Western Australia, p. 24.
[311] Health Networks, Department of Health, *WA Women's Health and Wellbeing Policy*, 2019, Government of Western Australia, p. 7-8, 10.
[312] WA Country Health Service, *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024*, 2019, Government of Western Australia, p. 3.

> Many people accessing mental health, alcohol and other drug services have experienced trauma in their lives. This can be as a result of early childhood abuse or neglect, assault, domestic violence or other traumatic experiences. TIC is delivered from a stand point of understanding the prevalence of trauma and of its impact upon a person's physical, emotional and mental health. This can impact an individual's behaviour and ability to engage with services, understanding that their response to this and some interventions can re-traumatise the individual.[313]

The *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026* was 'developed to provide strategic direction, leadership and best practice for North Metropolitan Health Service in response to the public health issue of family and domestic violence' and:

> … recognises the impacts of colonialism, inter-generational trauma, structural disadvantage, the destruction of culture, loss of cultural identity and the pervasion of racism and normalisation of systemic disadvantage faced by Aboriginal people as a driver of and context for their experience of violence.[314]

Further, the *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026* also highlights 'the high likelihood that victims of FDV have experienced trauma' and the importance of staff 'respond[ing] in a trauma-informed way'.[315] The Strategy describes 'trauma-informed care' and 'trauma informed health services' as follows:

> Trauma-informed care seeks to create safety for consumers by understanding the effects of trauma and its close links to health and behaviour … Trauma-informed care [also] involves understanding how trauma shapes a person's world view and functioning. Trauma-informed care will incorporate principles of safety, trust, collaboration and choice in service delivery. …
>
> A trauma informed health service includes incorporating trauma-informed policies such as allowing sufficient time (length of session) and continuity of care to engage with a consumer, spaces to have private and confidential discussions, and if possible, decisions made in collaboration and respectful of a consumer's choice. It also requires clear roles for staff and referral pathways both internally and externally. A key factor in supporting a consumer who discloses FDV is to provide them with information and support in response to their needs. Responses need to be culturally appropriate, culturally secure, and flexible to better meet the needs of consumers. [316]

6.5.6 The Aboriginal Empowerment Strategy identifies that healing trauma is an essential part of the strategy, emphasising trauma informed service delivery

The Aboriginal Empowerment Strategy, developed in partnership with the Aboriginal Advisory Council of WA, sets out how the Western Australian government 'will direct its efforts towards a future in which all Aboriginal people, families and communities are empowered to live good lives and choose their own futures from a secure foundation:'

[313] WA Country Health Service, *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024*, 2019, Government of Western Australia, p. 22.
[314] North Metropolitan Health Service, *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*, 2021, p. 6 and 12.
[315] North Metropolitan Health Service, *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*, 2021, p. 16.
[316] North Metropolitan Health Service, *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*, 2021, p. 16 and 22.

> The Strategy outlines a high-level framework for future state government policies, plans, initiatives and programs that contribute to better outcomes for Aboriginal people …
>
> … sets out the State's approach to meeting its commitments under the National Agreement on Closing the Gap …
>
> [and] consists of 10 strategic elements grouped into four themes, and a set of core principles. Together, these set the high-level direction for the WA Government, its agencies and staff to work towards achieving the Strategy's goal.[317]

As identified in section 5.5.1, the Aboriginal Empowerment Strategy identifies that healing trauma is a central and essential part of the strategy, noting that 'Aboriginal people have said very clearly that healing and trauma must be addressed for social and economic outcomes to improve.'[318] The Aboriginal Empowerment Strategy also identifies that services to Aboriginal and/or Torres Strait Islander people are to be 'family-focused, **trauma-informed** and directed to building strengths and reducing vulnerability,'[319] with its Policy Guide identifying that 'the Strategy's principles emphasise trauma-informed service delivery and guard against the creation of future traumas.'[320]

Trauma informed approaches to service delivery are also highlighted explicitly for Aboriginal and Torres Strait Islander children and young people. Western Australia's *Commitment to Aboriginal Youth Wellbeing*, the Government's response to the State *Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley*, and the 2016 Parliamentary Inquiry, *Learnings from the Message Stick: the report of the Inquiry into Aboriginal youth suicide in remote areas*, 'outlines how the Government of Western Australia proposes to work towards reducing the rate of suicide and enhancing the wellbeing of young Aboriginal people.'[321]

Commitment 5, 'building capacity in health and mental health services' identifies that 'induction and ongoing training of staff in cultural competency and trauma-informed care' is included as a key approach to building capacity in health and mental health services to 'deliver services to Aboriginal people that are flexible, responsive and culturally safe.'[322]

6.5.7 The Office did not identify detailed public sector guidance about what it means to be trauma informed

The Office identified that these strategies and frameworks recognise the importance of understanding trauma and identify the importance of trauma informed service delivery.

However, the Office did not identify a unified whole of government service approach or framework for creating shared definitions and understandings of trauma informed practice, its implementation and evaluation.

[317] Department of Premier and Cabinet, 'Aboriginal Empowerment Strategy – Western Australia 2021-2029,' 2021, viewed 3 October 2021, <https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/aboriginal-empowerment-strategy-western-australia-2021-2029>.
[318] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Strategy Overview*, 2021, p. 7.
[319] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Strategy Overview*, 2021, p. 14.
[320] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 11.
[321] Government of Western Australia, *Commitment to Aboriginal Youth Wellbeing*, 2020, p. 5.
[322] Government of Western Australia, *Commitment to Aboriginal Youth Wellbeing*, 2020, p. 24-25.

6.5.8 The term trauma informed is frequently used, but not always accompanied by clearly articulated definitions or approaches

In other countries and in Australia, some agencies are 'moving towards a trauma-informed paradigm for considering health and human service delivery systems:'[323]

> A systems approach to trauma-informed care means that implementation goes beyond individual practitioner and service organisation change to extend to whole systems that people who have experienced trauma are likely to interact with. A system, for example, could include the justice, homelessness or child welfare systems …
>
> Systemic change is important because it enables people to receive services that are sensitive to the impact of trauma regardless of whether they enter through any particular service setting or intervention.[324]

Researchers acknowledge that the implementation of trauma informed approaches at 'the systems level' is challenging 'due to the complex, dynamic nature of service systems.'[325] While the term 'trauma informed' is common, and used frequently across a range of service settings, some researchers highlight that 'there is not a common understanding of [trauma informed care],' or of how to implement it in different service settings. This 'causes confusion and difficulties in integrating and coordinating service delivery across sectors.'[326] Examining challenges faced by systems and services in implementing trauma informed approaches, with the Australian Institute of Family Studies identifies:

> With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services…
>
> Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.[327]

'In Australia, there is a demonstrated growing desire for, and provision of, training for trauma-informed care and practice among mental health professionals, child welfare services and other human service practitioners.'[328] In Western Australia, this desire is reflected in the aforementioned strategy frameworks, many of which have incorporated the voices of stakeholders including organisations, communities, and individuals with lived experience of family and domestic violence, suicide, and trauma.

[323] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 12.
[324] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 12-14.
[325] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 38.
[326] Domestic Violence Victoria, 'DV Vic Submission to Mental Health Royal Commission,' 2019, p. 19.
[327] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[328] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 41.

The research literature identifies that, while take-up of the idea of trauma informed approaches has been enthusiastic, 'leadership on framing trauma-informed care and collaborative initiatives to design, implement and evaluate organisational and systemic approaches are essential.' [329]

Recommendation 8: The Mental Health Commission, in collaboration with relevant State government departments and authorities and stakeholders, develop and disseminate a common understanding of what constitutes a trauma informed approach for Western Australian State government departments and authorities. Including, but not limited to:

- a definition and key principles of a trauma informed approach;
- domains of implementation (including, but not limited to, an organisation's strategic leadership, policy, training for staff, and evaluation);
- consideration of vicarious trauma in the service delivery context;
- this approach being intersectional, and elevates the voices and experiences of Aboriginal and/or Torres Strait Islander people; and
- a timeline for undertaking this work.

6.5.9 Some State government departments and authorities are incorporating trauma informed approaches into select service provision settings

In examining trauma informed approaches to service provision, and in consulting with State government departments and authorities, the Office identified that some work is already being done to incorporate trauma informed approaches to service provision in Western Australia.

The Department of Communities advised the Office that it utilises the Sanctuary Framework, a framework employed in residential care and secure care settings, facilities which are usually used by children who are in the care of the CEO:

> Many child protection interventions seeking to protect and support children and young people, such as removal from home and placement with strangers, as well as appearances in court, may increase a child or young person's trauma. This is a common experience of many of the children and young people within Residential and Secure Care.
>
> **Healing from Trauma with the Sanctuary Model**
>
> The Sanctuary Model is a trauma informed model for creating an organisational culture that provides an environment within which healing from traumatic experiences can be addressed. The Sanctuary Model (originated in the USA in the 1980's it was created by Dr Sandra Bloom and her colleagues) is comprised of four pillars …[330]

[329] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 36.
[330] Government of Western Australia, *Residential Care (CIC) and Secure Care Services Residential Framework*, 2020, Department of Communities, p. 2.

The Department of Communities' 'Therapeutic Care Guide,' a guide for use in out-of-home care settings, identifies observable measures through which staff may reflect upon therapeutic care practices, and identify gaps in knowledge, skill, and understanding.[331]

The Department of Justice advised the Office that work incorporating trauma informed care is being incorporated into several settings, including:

> **Women's Strategic Direction**
>
> …The [Women and Young People] directorate continues to [develop] a suite of documents which provide stakeholders with a clear understanding of the Departments intent with regard to the management of women in our care and expectation for the minimum standard of trauma informed practice within our facilities and services. These documents will provide an overarching philosophy, strategic direction, business planning framework and operational model for the prison facility's which comprise the Western Australian Women's Estate. The Women's Strategy project will articulate a clear direction of the Departments expectations and intended outcomes for the management of women held in prison custody within Western Australia both within the Women's Estate and in regional precincts.
>
> **Bindi Bindi Mental Health Unit at Bandyup Women's Prison**
>
> In 2015, a comprehensive survey of the mental health and substance use problems of prisoners recently arrived in prison in WA included a survey of reception prisoners at Bandyup Women's Prison (BWP)…The study found significantly higher prevalence of mental disorders, social disadvantage and needs among women compared to men.
>
> National data indicated the overwhelming majority of women in prison are victims of violence an experience experts attribute to their offending and criminalisation. Many prisoners have co-occurring mental health and AOD problems and cannot be admitted to any AOD rehabilitation prison unit until their mental health is stable. …
>
> As part of the WA Recovery Plan, Capital funding of $2,377,000 was requested and approved as part of the Government's COVID-19 stimulus to undertake capital works at Bandyup Women's Prison (BWP) to convert unit 1A into a Mental Health Unit to support the mental health needs of women and provide opportunity for women from across the state to transfer into the facility for the purpose of stabilising and addressing their mental health needs. The Unit provides a safe, secure, culturally appropriate and structured living environment with support facilities and services for women in custody with a mental illness requiring treatment.
>
> … The Unit's operating model is based on a number of key principals including individual, Trauma-informed and culturally sensitive care which realises the need for services to be guided by the women's needs not systematic requirements, the widespread impact of trauma and the need to tailor culturally sensitive services for women.
>
> Bandyup's Mental Health Unit is staffed by a multidisciplinary team of specialists and prison officers who work collaboratively and holistically with the women to provide the required care and support for improved wellbeing and

[331] Government of Western Australia, *Therapeutic Care Guide: Residential and Secure Care*, 2020, Department of Communities, p. 2.

> reintegration. Prison Officers nominate to work in the unit and are provided operational specific training for the unit to support trauma informed service delivery.
>
> **Working With Female Offenders six (6) module e-learning program**
>
> This is a 6 module e-learning package directed at all staff working with women. Module 2 specifically deals with a trauma informed approach however trauma informed practice is a key message throughout the entire package … WWFO e-learning package was launched in August 2021 to staff working within the women's estate and is currently being rolled out to all prison staff across WA. …
>
> **Vicarious trauma and the impact of the work on staff**
>
> The Departments Training Academy includes modules covering Trauma informed practice for prisoners and staff welfare as a component of the Prison Officer Entry Level Training Program and Vocational Services Officer course. Vicarious trauma and the impact of work on staff is the mandate of Employee Welfare, The Directorate monitor staff absenteeism, Workers Compensation and staff welfare to identify trends, however area managers are tasked with sourcing and providing appropriate training where required.[332]

6.5.10 Operationalising what it is to be trauma informed will vary across settings and systems

Researchers exploring the operation of frameworks for trauma informed approaches emphasise that 'a shared understanding about the overall philosophy and purpose of trauma-informed care [or practice]' and appropriate support 'to realise this paradigm shift' is crucial.[333] Trauma informed approaches 'must be based on principles, policies, and procedures that provide safety, voice and choice.'[334]

However, principles of trauma informed practice are not prescriptive, 'and cannot be given the wide range of possible service contexts in which they may be applied.'[335] In this context, the research literature highlights that an aspect of trauma informed approaches is that they 'must be culturally relevant' to the population served.[336]

> … The core idea behind trauma-informed systems is that they are relational, and human... It will also be difficult for others to prescribe. Each service, organisation and individual will need to work through how they can embrace the principles of trauma informed care, and then apply them in non-static ways to best meet the needs of the person in front of them.[337]

In identifying that the principles and practices of a trauma informed approach must be translated in a way that is relevant for unique service settings, researchers also identify that the nature of a trauma informed approach transcends isolated policies or procedures and

[332] Department of Justice, personal communication, 12 November 2021.
[333] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39-41
[334] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 27.
[335] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, Melbourne, p. 18.
[336] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 13.
[337] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 8.

may instead be used 'as a lens through which to focus on, create and then review all policies and procedures.' [338]

In this context, the Office also notes that, for many presenting issues, populations, and service provision contexts, trauma informed approaches are not the only important perspective requiring consideration. For example, in the context of supporting people with intellectual disability, Berry Street, an independent family service organisation in Victoria, identifies that:

> Perspectives that are culturally informed, developmentally informed, person-centred, family sensitive and have a human rights perspective are examples of other key complementary approaches to inform any system, service or workers supporting people with intellectual disability… they are understood as separate and significant paradigms in their own right.[339]

While the adoption of trauma informed approaches therefore requires leadership, guidance, and visibility about how this is being implemented, what it means to practice a trauma informed approach will vary in different settings. Accordingly, researchers identify that, to some extent, variability in how trauma informed approaches are 'translated into practice or operationalised in different settings' is expected:[340]

> As a 'paradigm shift' for organisations or systems that have not traditionally applied a trauma lens – and in some cases whose very purpose works against the principles of trauma informed care (for example, custodial settings) – the principles and practices of trauma-informed care need to be translated in such a way as to be meaningful and feasible in that setting. An organisation, system or setting that is built on statutory authority and legislated coercive powers, for example, will by necessity practice trauma-informed care in a very different way to a community health centre. This does not signal an inherent problem with the concept of trauma-informed care itself, and indeed reflects the challenges of operationalising an overall principle or ethos across multiple service systems. Wall and colleagues (2015) noted that being trauma informed involved a shift for services from being "trauma-blind" to trauma sensitive and on to trauma-informed. It is important not to see this continuum or process as a "typology" of level of being trauma-informed, but as a way of acknowledging that being aware of trauma in client populations is not sufficient to change systems and organisational cultures.[341]

Translating trauma informed approaches into practice also involves considering the needs of distinct workforces, and how staff in different settings engage with individuals, information, and are exposed to trauma.

[338] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, Melbourne, p. 39.
[339] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, Melbourne, p. 18.
[340] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.
[341] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.

In identifying that the implementation of a trauma informed approaches is a 'paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time,' researchers have identified a continuum of implementation for organisations increasing their awareness of trauma. This continuum of implementation begins 'with becoming trauma aware and … [moving] to trauma sensitive to responsive to being fully trauma informed:'[342]

1. **Trauma aware:** where staff understand trauma and how individuals may have behavioural presentations in response to traumatic experiences.

2. **Trauma sensitive**: where an organisation's work practice can operationalise some concepts of a trauma-informed approach.

3. **Trauma responsive**: where the individual and organisational response enables changes in behaviour and strengthens resilience and protective factors.

4. **Trauma-informed**: where the culture of the whole system reflects a trauma-informed approach in all work practices and settings.[343]

Te Pou o te Whakaaro Nui (**Te Pou**), New Zealand's National Centre of Mental Health Research, Information and Workforce Development, has undertaken work including a review 'to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness, and factors supporting implementation.'[344] As part of this research, Te Pou has highlighted that specific strategies for implementing trauma informed approaches 'are common in the literature,' and can be grouped in to four broad areas, including:

1. Transferring knowledge to practice by realigning organisation processes and systems needed for the workforce and people accessing services.

2. Identifying barriers to implementation.

3. Addressing workforce wellness and safety.

4. Developing workforce skills and confidence needed to support people with experience of trauma.[345]

As trauma 'affects a large proportion of the population' and survivors 'are clients in a broad range of human services,' organisations across all settings 'should consider how trauma-informed approach could benefit stakeholders,' and how such an approach would operate in its own unique context.[346]

In conducting research commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse, researchers identified 'the first question for organisations and service settings to ask is':

[342] Missouri Department of Mental Health, 'Missouri Model: A Developmental Framework for Trauma Informed Approaches,' 2019, p. 1, viewed 11 November 2021 <https://dmh.mo.gov/media/pdf/missouri-model-developmental-framework-trauma-informed-approaches> and Blue Knot Foundation, 'Foundations for Building Trauma Awareness: Professional Development Training Booklet', delivered 17 September 2021.
[343] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, p. 38.
[344] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, 2018, p. 8.
[345] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, p. 45.
[346] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.

> Given what we know about the impacts of trauma on the people we serve, what can we change in our policies, protocols, hiring practices, training, physical environment and general practice to ensure that, in performing our core business, we do not, at a minimum, retraumatise our service users (or clients, patients or students), and hopefully work with them in a strengths-based and future-oriented way?[347]

Recommendation 9: Taking into account the outcome of Recommendation 8, the Western Australia Police Force; the Department of Justice; the Department of Health; and the Department of Communities each:

- consider how a trauma informed approach may be incorporated into their operations; and
- work to improve their organisation's understanding of trauma.

[347] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.

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Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	October 2022
A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee	September 2022
A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020	September 2021
An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	July 2021
Preventing suicide by children and young people 2020	September 2020
A report on giving effect to the recommendations arising from 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

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