



Preventing suicide by children and young people 2020

Volume 1: Ombudsman's Foreword and Executive Summary

Ombudsman Western Australia
Serving Parliament – Serving Western Australians

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 future.

CONTENT WARNING

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

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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:

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

Child and Adolescent Mental Health Service Emergency Telehealth: 1800 048 636

mental health crisis management, assessment and referral services, 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

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

free phone, video and online counselling for people 15 years and older, who are suicidal, caring for someone who is suicidal, bereaved by suicide, or geographically or emotionally isolated

Lifeline: 13 11 14 or lifeline.org.au

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

beyondblue: 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)

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

phone, video and web counselling for men of all ages with emotional health and relationship concerns

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

Additional support services

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

Health and medical support for Aboriginal people, including counselling, Mon-Fri 8.30 am to 7 pm, Saturdays 8.30 to 12 pm

Social and Emotional Wellbeing and Mental Health Service: sewbmh.org.au

'Find a Health Service' search for Aboriginal and Torres Strait Islander People-specific social and wellbeing services and programs across Australia

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

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

6 am to 2 am, seven days a week, anonymous and confidential telephone support

Mental Health in Multicultural Australia: mhima.org.au

for people from culturally and linguistically diverse backgrounds

QLife: 1800 184 527 or qlife.org.au

3 pm – 12 am, seven days per week, counselling and referral service for LGBTI people

MindOUT!: lgbtihealth.org.au/mindout

for LGBTIQ+, other sexuality, sex and gender diverse people

1800RESPECT: 1800 737 732

24 hour, national sexual assault, domestic violence counselling service

Crisis Care Helpline: 9223 1111 or 1800 199 008

24 hour, urgent assistance with child safety, family and domestic violence, homelessness and other crisis situations for Western Australians

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](http://NationalRelayService.org.au) or via their Helpdesk on 1800 555 660 and quote 08 9220 7555 to be connected with the Ombudsman's office.

Ombudsman's Foreword

As part of my responsibility to review the deaths of Western Australian children I present to Parliament, *Preventing suicide by children and young people 2020*. The report is comprised of three volumes: Volume 1 an executive summary; Volume 2 an examination of the steps taken to give effect to the recommendations arising from the report of my 2014 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people (the 2014 Investigation)*; and Volume 3, the report of my 2020 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people (the 2020 Investigation)*.

The 2014 Investigation examined the deaths of 36 young people aged 14 to 17 years. Arising from my findings, I made 22 recommendations to four agencies, namely, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support, all of which were accepted by these agencies. I am very pleased to report to Parliament that I have found that steps have been taken or are proposed to be taken (or both) for each of the 22 recommendations as set out in Volume 2 of the report.

The 2020 Investigation examines a further 79 deaths by suicide that occurred following the 2014 Investigation, as set out in Volume 3. The 2020 Investigation examines what is known about suicide and self-harm by Western Australian children and young people, the research literature, current strategic frameworks, and data obtained during our investigation. Significantly, it also collates State-wide suicide and self-harm data relating to Western Australian children and young people over the 9 years from 1 July 2009 to 30 June 2018 for the first time, including:

- deaths by suicide; and
- hospital admissions and emergency department attendances for self-harming and suicidal behaviour.

Arising from the 2020 Investigation, I have made seven recommendations to four government agencies about preventing suicide by children and young people, including the development of a suicide prevention plan for children and young people to focus and coordinate collaborative and cooperative State government efforts. I am very pleased that each agency has agreed to these recommendations and has, more generally, been positively engaged with our investigation. These recommendations are notable not by their number, but by the fact that we have sought to make highly targeted, achievable recommendations regarding critical issues. Further we have ensured that the recommendations do not duplicate the work of other investigations and inquiries.

The new information gathered, presented and comprehensively analysed in the 2020 Investigation will be, I believe, a very valuable repository of knowledge for government agencies, non-government organisations and other institutions in the vital work that they undertake in developing and assessing the efficacy of future suicide prevention efforts in Western Australia.

Preventing suicide by children and young people is a shared responsibility requiring collaboration, cooperation and a common understanding of past deaths, risk assessment and responsibilities. The complex and dynamic nature of the risk and protective factors associated with suicide requires a varied and localised response, informed by data about self-harm and suicide, and other indicators of vulnerability experienced by our children and young people. Ultimately, suicide by children and young people will not be prevented by a single program, service or agency working in isolation. Preventing suicide by children and young people must be viewed as part of the core, everyday business of each agency working with children and young people.

The 115 children and young people who died by suicide considered as part of my 2014 and 2020 Investigations will not be forgotten by their parents, siblings, extended family, friends, classmates and communities. I extend my deepest personal sympathy to all that continue to grieve their immeasurable loss.

It is my sincerest hope that the extensive new information in this report about suicide by children and young people, and its recommendations, will contribute to preventing these most tragic deaths in the future.

A handwritten signature in black ink, appearing to read 'Chris Field', with a large, stylized initial 'C'.

Chris Field

Executive Summary

1. Introduction

Suicide by children and young people in our community is an immeasurable tragedy. Suicide is the leading cause of death for Australian children and young people aged 5 to 17 years.¹ In Western Australia, suicide is the most frequent circumstance of death of young people aged 13 to 17 years notified to the Ombudsman, and 16 per cent of all notified child deaths since the commencement of the Ombudsman's child death review function on 30 June 2009.

Government agencies, through collaborative policy development and service provision, have a vital role to play in preventing suicide by children and young people. Understanding the experiences of children and young people who died by suicide and their interactions with State government agencies, is critical to improving public administration and the effectiveness of suicide prevention efforts.

This Executive Summary (**Volume 1**) brings together the findings and recommendations arising from two major investigations undertaken by the Ombudsman under the *Parliamentary Commissioner Act 1971*, namely:

- an investigation on giving effect to the recommendations arising from the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people 2014 (Volume 2)*; and
- the Ombudsman's second investigation into preventing suicide by children and young people (**Volume 3**).

Preventing suicide by children and young people 2020 (Volumes 1 – 3), presents together, for the first time:

- details about the steps taken by the Mental Health Commission, WA Health, the Department of Education and the Department of Communities to prevent and reduce suicide by children and young people;
- a summary of recent research literature examining the contributing factors, pathways to suicide by children and young people, and effective evidence-based interventions to prevent and reduce suicide by children and young people;
- state-wide statistics on suicide and self-harm by children and young people;
- information about the risk factors associated with suicide experienced by children and young people who died by suicide;
- information about the interactions between State government agencies and children and young people who died by suicide; and
- seven new recommendations made by the Ombudsman about ways that State government departments and authorities can prevent suicide by children and young people.

¹ ABS, 'Intentional self-harm, key characteristics', Causes of Death, Australia, 2018, Cat No.: 3303.0.

It builds upon the Ombudsman's earlier *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people 2014* and analyses the deaths of 115 children and young people notified to the Ombudsman in circumstances of apparent suicide during the 9-year period from 1 July 2009 to 30 June 2018, including:

- the deaths of 36 young people which occurred during a 3.5 year period commencing 1 July 2009 that were analysed by the office of the Ombudsman (**the Office**) in the 2014 Investigation (**the 36 young people**); and
- the deaths of 79 children and young people which occurred during a 5.5 year period ending 30 June 2018 (**the 79 children and young people**).

2. The role of the Ombudsman

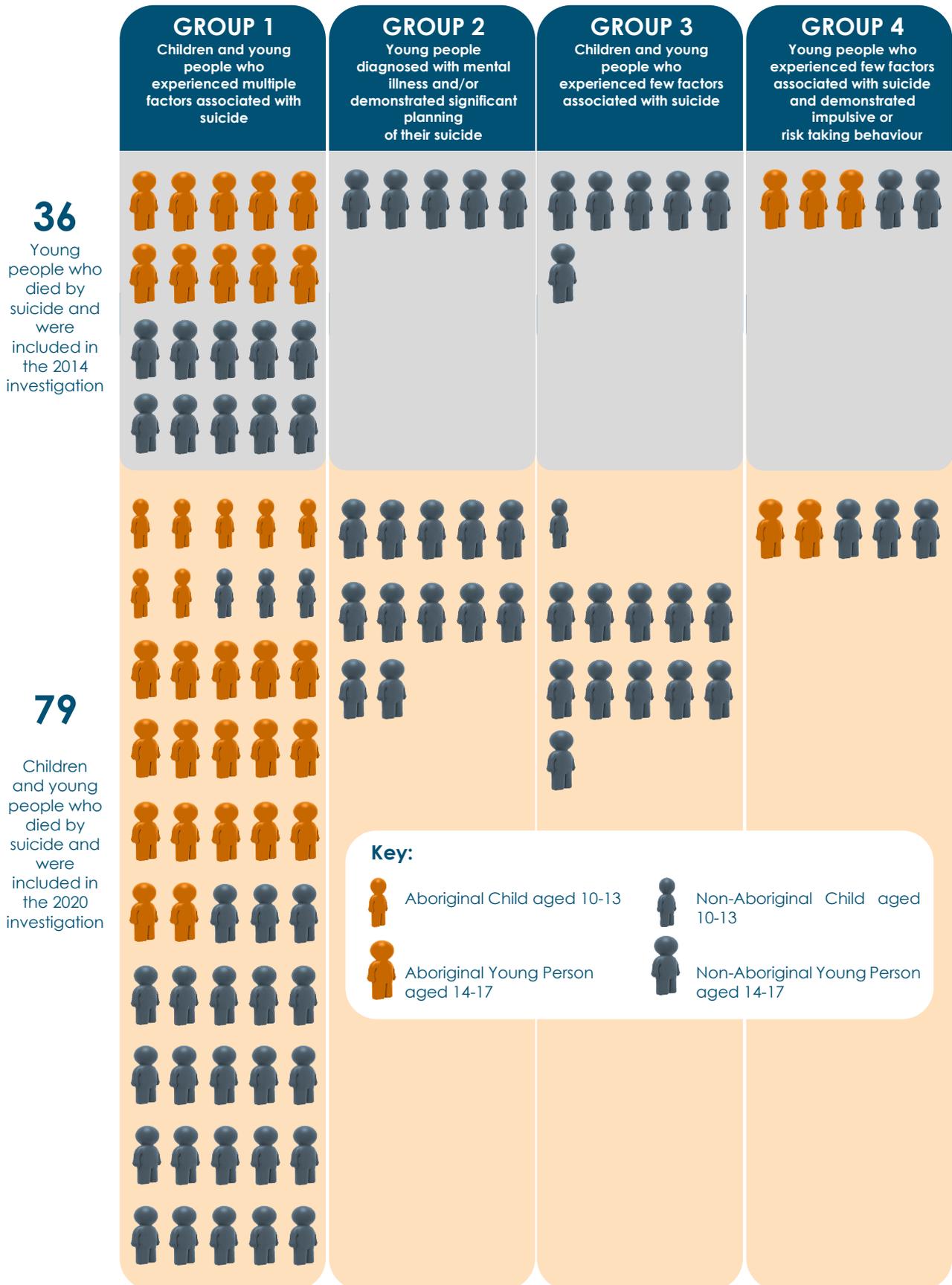
On 30 June 2009, amendments to the *Parliamentary Commissioner Act 1971* (**the Act**) commenced into effect, granting an important new child death review function to the Ombudsman. The child death review function enables the Ombudsman to review investigable deaths where the child, or their family, was 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.

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



3. The 2014 Investigation

The Ombudsman's child death reviews identified that:

- of the child death notifications received by his office since he commenced his child death review responsibilities, nearly a third related to young people aged 13 to 17 years;
- suicide was the most common circumstance of death for young people aged 13 to 17 years, accounting for nearly 40 per cent of deaths; and
- Aboriginal young people were very significantly over-represented in the number of young people who died by suicide.

For the above reasons, the Ombudsman decided to undertake a major own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by young people.

The 2014 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 patterns in the characteristics of the 36 young people, including the risk factors, warning signs and precipitating events experienced by the 36 young people (referred to as **factors associated with suicide**) as summarised in Figure 2.

Figure 2: Factors associated with suicide used in this report

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

Source: Ombudsman Western Australia

The 2014 Investigation identified four groups of young people based on patterns in the factors associated with suicide, contact with State government departments and authorities, and relevant suicide prevention activities, as follows:

Figure 3: Groups identified in the 2014 Investigation

Group 1	Group 2	Group 3	Group 4
Characteristics			
<p>20 young people:</p> <ul style="list-style-type: none"> all allegedly experienced one or more forms of child abuse or neglect; most also experienced mental health issues and suicidal ideation and behaviour. 	<p>5 young people who had:</p> <ul style="list-style-type: none"> 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 	<p>6 young people who:</p> <ul style="list-style-type: none"> 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. 	<p>5 young people who:</p> <ul style="list-style-type: none"> 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			
<p>All of the young people in Group 1 were known to the:</p> <ul style="list-style-type: none"> (then) Department for Child Protection and Family Support; and Department of Health. <p>These young people also had extensive contact with other State government department and authorities including registered training organisations, the justice system and the Department of Housing.</p>	<p>Most of the young people in Group 2 had contact with the (then) Child and Adolescent Mental Health Service and government schools.</p>	<p>The young people in Group 3 had minimal contact with State government departments and authorities.</p> <p>Some were known to the Department of Health and/or had contact with a registered training organisation.</p> <p>Most attended private schools.</p>	<p>All of the young people in Group 4 had contact with the Department of Health and government schools.</p> <p>Most were also known to the (then) Department for Child Protection and Family Support for financial or crisis support.</p>
Relevant suicide prevention activities			
<p>Interventions that recognise and address the developmental impacts of child abuse, neglect and other forms of childhood adversity, including:</p> <ul style="list-style-type: none"> 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. 	<p>Interventions that promote and enhance mental health, including:</p> <ul style="list-style-type: none"> symptom identification; early, standard and longer term treatment of mental health problems; and ongoing care and support. 	<p>Universal, selective and indicated interventions.</p> <p>Further research may be required.</p>	<p>Universal interventions.</p> <p>Selective and indicated interventions, targeting at risk Aboriginal and/or rural communities and individuals.</p>

Source: Ombudsman Western Australia

The 2014 investigation found that State government departments and authorities had already undertaken a significant amount of work that aimed to reduce and prevent suicide by young people in Western Australia, however, there was still more work to be done. In particular, the Ombudsman identified a number of practical opportunities for the Mental Health Commission, Department of Health, (then) Department for Child Protection and Family Support and Department of Education to enhance their provision of services to young people. Relevantly, the Office's analyses identified:

- that the (then) State Suicide Prevention Strategy *Western Australian Suicide Prevention Strategy 2009- 2013: Everybody's Business* was focussed on the Prevention category of suicide prevention activities that should continue. However, the Office found that the factors associated with suicide experienced by 25 (69 per cent) of the 36 young people may align with the Treatment and Continuing Care categories of suicide prevention and the development of differentiated strategies for suicide prevention may be needed for each group;
- differences between the experiences of young people in Group 1 and Group 2, particularly with respect to acceptance of referrals by Child and Adolescent Mental Health Services and risk assessments;
- that a majority of the 36 young people were recorded as having allegedly experienced more than one form of child abuse or neglect, and were therefore likely to have experienced cumulative harm. Further, although some of the (then) Department for Child Protection and Family Support's policies and procedures addressed the need to undertake holistic, trauma informed assessments of cumulative harm these concepts had not been extended to other relevant elements of the policy framework and casework guidance materials;
- that 95 per cent of the young people in Group 1 were enrolled in an educational program at the time of their death, a majority of whom attended school less than 60 per cent of the time. However, limited action under the *School Education Act 1999* and Department of Education *Student Attendance* policy was taken to address these attendance issues; and
- that because the reasons for suicide by young people are multi-factorial and cross a range of government agencies, practical tools for information sharing and the development of a collaborative inter-agency approach to preventing suicide by young people should be considered for 'hard to help' young people who have experienced multiple risk factors and a long history of involvement with multiple agencies such as those in Group 1.

Arising from the 2014 Investigation's findings, the Ombudsman made 22 recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people directed to the Mental Health Commission, the (then) Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education broadly aimed at:

- developing differentiated strategies for suicide prevention relevant to each of the four groups of young people who died by suicide for inclusion in the Western Australian Suicide Prevention Strategy (Recommendations 1, 2 and 3);

- improving service delivery and the rate at which operational policy is implemented into practice within the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education (Recommendations 4 - 21); and
- promoting inter-agency collaboration between the Mental Health Commission, Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, through consideration of a joint case management approach and shared tools for use with young people experiencing multiple risk factors associated with suicide (Recommendation 22).

**Table 1: Recommendations arising from the Ombudsman's
*Investigation into ways that State government departments and
 authorities can prevent or reduce suicide by young people 2014***

Recommendation	Theme
<p>Recommendation 1: As part of the development of the State Strategy past 2013, the Mental Health Commission considers developing differentiated strategies relevant to each of the four groups of young people, taking into account the findings of the investigation regarding the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities.</p>	<p style="text-align: center;">Developing differentiated suicide prevention strategies for young people (Mental Health Commission)</p>
<p>Recommendation 2: The Mental Health Commission, in collaboration with relevant stakeholders, considers whether it may be appropriate to undertake, or facilitate the undertaking of, mental health literacy and suicide prevention activities for those young people who demonstrate few factors associated with suicide, as identified by the investigation.</p>	
<p>Recommendation 3: As part of the development of the State Strategy past 2013, the Mental Health Commission gives consideration to whether the scope of the State Strategy should be expanded to encompass the Treatment and Continuing Care categories of suicide prevention, by incorporating the investigation's recommendations about ways that State government departments can prevent or reduce suicide by young people.</p>	
<p>Recommendation 4: The Department of Health considers the findings of this investigation in determining their state-wide provision of mental health services for young people.</p>	<p style="text-align: center;">Improving public mental health services for young people through enhanced policy implementation (Department of Health)</p>
<p>Recommendation 5: The Department of Health ensures that Child and Adolescent Mental Health Service applies the priorities for acceptance of referrals set out in its policies</p>	
<p>Recommendation 6: The Department of Health, where services are available, assists with the coordination of services from other government and non-government mental health services for young people who have been placed on a waitlist for services from the Child and Adolescent Mental Health Service.</p>	
<p>Recommendation 7: Where a young person is referred to the Child and Adolescent Mental Health Service but not accepted by the Child and Adolescent Mental Health Service, the Department of Health notifies the referrer that the young person has not been accepted.</p>	
<p>Recommendation 8: The Department of Health ensures that risk assessments undertaken by the Child and Adolescent Mental Health Service are conducted in accordance with the Clinical Risk Assessment and Management policy and the findings of the Chief Psychiatrist, including for young people who present with a history of child maltreatment.</p>	

Recommendation	Theme
<p>Recommendation 9: The Department for Child Protection and Family Support considers whether an amendment to the <i>Children and Community Services Act 2004</i> should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.</p>	<p>Improving child protection services for young people through enhanced policy implementation (Department for Child Protection and Family Support)</p>
<p>Recommendation 10: The Department for Child Protection and Family Support considers the revision of its relevant policies and procedures to recognise, consider and appropriately respond to cumulative harm that is caused by child maltreatment.</p>	
<p>Recommendation 11: The Department for Child Protection and Family Support enables and strengthens staff compliance with the policies and procedures that are applicable to the duty interaction process.</p>	
<p>Recommendation 12: The Department for Child Protection and Family Support enables and strengthens staff compliance with any revised policies and procedures which require them to assess the potential for cumulative harm to have occurred as a result of child maltreatment.</p>	
<p>Recommendation 13: In considering revisions to its policies and procedures to recognise cumulative harm, the Department for Child Protection and Family Support considers incorporating requirements to consult with Aboriginal Practice Leaders when the potential for cumulative harm is being assessed for Aboriginal young people.</p>	
<p>Recommendation 14: The Department for Child Protection and Family Support uses information developed about young people who are likely to have experienced cumulative harm as a result of child maltreatment to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.</p>	
<p>Recommendation 15: The Department of Education ensures that schools comply with the requirements for addressing student non-attendance, as set out in the <i>School Education Act 1999</i> and the <i>Student Attendance</i> policy.</p>	<p>Improving education services for young people through enhanced policy implementation (Department of Education)</p>
<p>Recommendation 16: The Department of Education considers expanding its <i>Student Attendance</i> policy to:</p> <ul style="list-style-type: none"> • recognise that persistent non-attendance by a student may be due to cumulative harm resulting from child maltreatment; • recognise that these students may be at heightened risk of suicide; • set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and • provide that, where this association is identified, it will be appropriately taken into account. 	
<p>Recommendation 17: The Department of Education ensures that schools comply with the requirements for managing student behaviour, as set out in its <i>Behaviour Management in Schools</i> policy.</p>	
<p>Recommendation 18: The Department of Education considers its expansion of its <i>Behaviour Management in Schools</i> policy to:</p> <ul style="list-style-type: none"> • recognise that ongoing behavioural difficulties by a student resulting in multiple suspensions and exclusions may be due to cumulative harm resulting from child maltreatment; • recognise that these students may be at heightened risk of suicide; • set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and • provide that, where this association is identified, it will be appropriately taken into account. 	

Recommendation	Theme
<p>Recommendation 19: The Department of Education ensures that schools comply with the additional requirements for addressing non-attendance by Aboriginal students, as set out in the <i>Student Attendance</i> policy.</p>	
<p>Recommendation 20: The Department of Education identifies young people who are exhibiting difficulties by establishing internal procedures to track when:</p> <ul style="list-style-type: none"> • a young person's attendance has fallen below 60 per cent; • a young person's name has been placed on the Students whose Whereabouts are Unknown list; • a young person has been suspended from attendance at school on two or more occasions; and • a young person has been excluded from school. 	
<p>Recommendation 21: The Department of Education uses the information obtained through tracking attendance, suspensions and exclusions to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.</p>	
<p>Recommendation 22: The Mental Health Commission, working together with the Department of Health, the Department for Child Protection and Family Support and the Department of Education, considers the development of a collaborative inter-agency approach, including consideration of a shared screening tool and a joint case management approach for young people with multiple risk factors for suicide.</p>	<p style="text-align: center;">Promoting inter-agency collaboration (Mental Health Commission, Department of Health, Department for Child Protection and Family Support and Department of Education)</p>

Source: Ombudsman Western Australia

4. **Volume 2: A report on giving effect to the recommendations arising from the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people 2014***

Volume 2 sets out each of the Ombudsman's 22 recommendations arising from the 2014 Investigation and the Office's consideration of:

- the steps that have been taken to give effect to the recommendations;
- the steps that are proposed to be taken to give effect to the recommendations; or
- if no such steps have been, or are proposed to be taken, the reasons therefor.

Volume 2 also considers whether the steps taken, proposed to be taken or reasons for taking no steps:

- seem to be appropriate; and
- have been taken within a reasonable time of the making of the recommendations.

The Office's consideration of the steps taken to give effect to the recommendations of the 2014 Investigation was informed by:

- information provided by agencies;
- consultation with State government and non-government leaders in youth suicide prevention;
- additional information relevant to suicide by young people in Western Australia since the 2014 Investigation; and
- current national and international literature regarding suicide by children and young people and the associated risk factors.

The Ombudsman has found that steps have been taken or are proposed to be taken (or both) for all of the recommendations arising from the 2014 Investigation. However, the work of the Ombudsman's office in ensuring that the recommendations of the investigation are given effect does not end with the tabling of this report.

As set out in Volume 2, the Ombudsman's office will continue to monitor and report on the steps taken to give effect to the recommendations arising from the 2014 Investigation.

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

In the time since the 2014 Investigation, suicide has continued to be the leading cause of death of Australian children and young people. This has also been reflected in the child death notifications received by the Ombudsman, with suicide remaining the leading circumstance of investigable and non-investigable deaths of young people aged 13 to 17 years.

Sadly, a new trend has also emerged from the child death notifications received by the Office. Suicide has increased as a circumstance of death notified to the Ombudsman in the 6 to 12 year old age group, particularly of those children with a history of child protection involvement with the Department of Communities, and now accounting for:

- 5 per cent of child death notifications for the 6 to 12 year old age group; and
- 13 per cent of the investigable deaths of children aged 6 to 12 years.

The research literature published since the 2014 Investigation also identified that little was known about suicide by children, as compared to suicide by young people, because 'the numbers of deaths are low' and:

Efforts to extrapolate from what is known about adolescent suicide is not accurate or helpful as children and adolescents differ in relation to physical, sexual, cognitive and social development.²

Accordingly, after reviewing information arising from these child death reviews, the initial information provided about the steps taken to give effect to the recommendations arising from the 2014 Investigation and current literature on suicide by children and young people, the Ombudsman decided to commence a new own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people.

² headspace, Understanding suicide, suicide attempts and self-harm in primary school aged children, viewed 28 February 2019, <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf?>>, p. 1.

This second investigation (**the 2020 Investigation**) aimed to:

- further develop and build upon the detailed understanding of the nature and extent of involvement between the children and young people who died by suicide and State government departments and authorities;
- identify any continuing, new or changed patterns and trends in the demographic characteristics and social circumstances of the children and young people who died by suicide; circumstances of the deaths by suicide; risk factors associated with suicide experienced by the children and young people; and their contact with State government departments and authorities; and
- based on this understanding, identify ways that State government departments and authorities can prevent or reduce suicide by children and young people, and make recommendations to these departments and authorities accordingly.

The 2020 Investigation analysed the deaths of a further 79 children and young people who either:

- died by suicide (for those deaths where the State Coroner had completed an investigation and found that the cause of death was suicide or made an open finding that suicide may have been the cause of death); or
- were suspected of having died by suicide (for those deaths where the State Coroner had not yet completed an investigation).

It also considers the 79 children and young people as part of a totality of 115 children and young people who died by suicide (including the 36 young people from the 2014 Investigation) in Western Australia between 1 July 2009 and 30 June 2018.

5.1 Characteristics of the 115 children and young people who died by suicide

The Office received notification of:

- 36 young people who died by suicide during the 2014 Investigation period (3.5 years, commencing 1 July 2009); and
- 79 children and young people who died by suicide during the 2020 Investigation period (5.5 years, ending 30 June 2018).

Most the 115 children and young people were male (72 children and young people, or 63 per cent).

The number of deaths appeared to increase with age, as did the proportion of males, with over half (69 young people, or 60 per cent) aged 16 or 17 years at the time of their death. Within the 16 to 17 years age group, male young people were over-represented (49 male young people among the 69 young people aged 16 or 17 years at the time of their death, 71 per cent). However, in the younger cohort of 10 to 13 year old children, the majority were female (7 female children, 64 per cent).

Aboriginal and Torres Strait Islander children and young people were significantly over-represented among the 115 children and young people. Forty-three of the 115 children and young people were recorded as identifying as Aboriginal or Torres Strait Islander (37 per cent). For comparison, 7 per cent of children and young people aged 0 to 17 years in Western Australia are Aboriginal and/or Torres Strait Islander.³

The majority of the 115 children and young people were residing in the Perth metropolitan area at the time of their death (66 children and young people, 57 per cent). Using remoteness categories defined by the Australian Bureau of Statistics, 49 of the 115 children and young people (43 per cent) resided in a remote or regional area⁴ at the time of their death, as follows:

- 22 children and young people were residing in a regional area (19 per cent);
- 8 children and young people were residing in a remote area (7 per cent); and
- 19 children and young people were residing in a very remote area (17 per cent), all of whom were Aboriginal or Torres Strait Islander.

³ Population distribution for children and young who identify as Aboriginal and aged between 5 and 19 years obtained from: Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2016', *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.

⁴ Australian Bureau of Statistics, *Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure*, cat. no. 1270.0.55.005, ABS, Canberra, July 2011.

Table 2: Demographic characteristics, for the 115 children and young people, by Ombudsman Investigation

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

Source: Ombudsman Western Australia

⁵ Socio-Economic Indexes for Areas rank geographic areas in terms of their socioeconomic characteristics. The Office assigned scores from the ABS 2016 Index of Relative Disadvantage (IRD) SEIFA based on residential postcode at the time of death. Quintiles were also assigned based upon the State-based decile ranks. Scores lower than 1000 indicate areas with disadvantaged socio-economic characteristics but do not convey any information about individual a child, young person or their family's socioeconomic status.

5.2 Circumstances of death

The most common mechanism of death was hanging (98 children and young people, or 85 per cent), followed by jumping or lying in front of a moving object (5 young people, or 4 per cent). The majority of deaths occurred at the child or young person's home (76 children and young people, 66 per cent).

The number of children and young people who died by suicide was highest in March, November and December, and lowest in February and September.

Table 3: Circumstances of death, for the 115 children and young people, by Ombudsman Investigation

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

Source: Ombudsman Western Australia

5.3 Patterns and trends in the groupings of children and young people who died by suicide

The patterns identified by the Office in the 2014 Investigation were consistent with similar investigations carried out by Child Death Review teams in New South Wales⁶, Queensland⁷ and British Columbia, Canada⁸, each of which identified two broad groups of young people who died by suicide:

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

Australian Child Death Review teams have identified patterns and trends in the characteristics and experiences of children and young people who died by suicide, similar to those identified in the 2014 Investigation. The New South Wales Death Review Team identified that 'the degree to which the young people [who died by suicide] were identified to be at risk before they died was a long a continuum' including three groups of young people:

- Young people with serious ongoing difficulties, complex needs and a clearly identified risk of suicide; ...
- Young people with some identified coping difficulties or challenges, but not considered to be at risk of suicide; ...
- Young people for whom there were no evident indicators that they required support or assistance ...⁹

Similarly, the South Australian Child Death and Serious Injury Review Committee identified four groups among a cohort of young people who died by suicide:

Group 1 ... young people who have disengaged from home, school, community and other forms of support.

Group 2 ... young people who experience anxiety, depression and other emerging mental health issues in their teenage years.

Group 3 ... young people who have no identifiable risk factors, and are not involved with support services.

⁶ Sankey S and Lawrence R, *Suicide and risk-taking deaths of children and young people*, New South Wales Commissioner for Children and Young People, Sydney, 2003.

⁷ Commissioner for Children and Young People and Child Guardian, *Reducing Youth Suicide in Queensland: Final Report*, Queensland Government, Brisbane, 2011.

⁸ Government of British Columbia, Child Death Review Unit, *Looking for something to look forward to: A five-year retrospective review of child and youth suicide in BC*, Child Death Review Unit, Burnaby, 2008.

⁹ Wolf M, Child Death Review Team, NSW Ombudsman, *Submission No. 45 to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW*, August 2017, viewed 26 October 2019, <<https://www.parliament.nsw.gov.au/ladocs/submissions/58726/Submission%2045%20-%20Child%20Death%20Review%20Team,%20NSW%20Ombudsman.PDF>>, pp. 8-9.

Group 4 ... [young people for whom] the [Child Death] Committee does not have enough information about ... to determine common themes in their lives.¹⁰

5.3.1. Among the 115 children and young people who died by suicide in Western Australia, there continue to be four identifiably distinct groups of children and young people

In order to further investigate patterns and trends in the lives of the children and young people who died by suicide in Western Australia during the 2020 Investigation, the Office repeated the analysis of the factors associated with suicide for the 79 children and young people using:

- information from child death review notifications;
- other information and records obtained during child death reviews conducted by the Office; and
- information obtained from the Department of Communities, Department of Education and Mental Health Commission.

Group 1 (children and young people who allegedly experienced one or more forms of child abuse or neglect) remains the largest group of children and young people who died by suicide (70 children and young people, 61 per cent). 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.

Thirty-one of the 70 children and young people in Group 1 (44 per cent) allegedly experienced some form of homelessness during their lives (as defined by the Australian Bureau of Statistics). For comparison, it is estimated that in 2016, 0.4 per cent of children under 12 and 0.5 per cent of 12 to 18 year olds were experiencing primary or secondary homeless in Australia.¹¹

The proportion of children and young people who died by suicide in Groups 2 and 3 across the 2014 and 2020 Investigations was similar, with:

¹⁰ Government of South Australia, Child Death and Serious Inquiry Review Committee, *Suicide Prevention and Child Death Review*, 10 October 2018, viewed 26 October 2019, <<http://www.cdsirc.sa.gov.au/>>.

¹¹ Australian Bureau of Statistics, *Census of Population and Housing: Estimating homelessness, 2016, Youth Homelessness*, cat. no 2049.0, ABS, Canberra, March 2018; Estimated resident population in Australia obtained from: Australian Bureau of Statistics, 'Table 59: Estimated resident population by single year of age, Australia', *Australian Demographic Statistics*, cat. no. 3101.0, ABS, Canberra, June 2018.

- a total of 17 of the 115 children and young people (15 per cent) in Group 2 (comprised of children and young people with a diagnosed mental health condition and/or self-harming; or had a parent with a diagnosed mental health condition);
- a total of 18 of the 115 children and young people (16 per cent) in Group 3 (comprised of high academic or sporting achievers, with few factors associated with suicide and very little contact with State government departments and authorities).

Group 4 remained the smallest of the groups identified by the Office amongst the 115 children and young people, comprising 10 young people (9 per cent) who experienced few factors associated with suicide, other than some occasions of impulsive or risk-taking behaviours.

Table 4: Demographic characteristics of the 115 children and young people who died by suicide, by group and investigation

	Group 1 Multiple risk factors associated with suicide, alleged experiences of abuse and/or neglect			Group 2 Diagnosed with one or more mental illnesses/disorders, living with a parent with a mental illness/bereaved by parental suicide			Group 3 High academic or sporting achievers, few risk factors, no alleged abuse or neglect			Group 4 Recorded risk-taking behaviours, no alleged abuse or neglect		
Investigation Period												
	2014	2020	2009-10 to 2017-18 ¹²	2014	2020	2009-10 to 2017-18	2014	2020	2009-10 to 2017-18	2014	2020	2009-10 to 2017-18
Number of children and/or young people												
Children (10-13 years)	0	10	10	0	0	0	0	1	1	0	0	0
Young People (14-17 years)	20	40	60	5	12	17	6	11	18	5	5	10
TOTAL	20	50	70	5	12	17	6	12	18	5	5	10
Age												
Minimum	14	10	10	15	14	14	16	13	13	14	14	14
Maximum	17	17	17	17	17	17	17	17	17	17	17	17
Median	15.5	16.0	16.0	16.0	16.5	16.0	16.0	17.0	16.0	17.0	16.0	16.5
Average	15.7	15.2	15.3	16.0	16.1	16.1	16.0	16.1	16.1	16.2	15.8	16.0
Sex												
Female	10	25	35	3	1	4	0	2	2	1	1	2
Male	10	25	35	2	11	13	6	10	16	4	4	8
Aboriginality												
Aboriginal or Torres Strait Islander	10	27	37	0	0	0	0	0	0	2	3	5
Non-Aboriginal	10	23	33	5	12	17	6	12	18	3	2	5
Remoteness of residence												
Major Cities	10	23	33	4	8	12	5	10	15	2	4	6
Regional	6	9	15	1	3	4	1	0	1	1	0	1
Remote and Very Remote	4	18	22	0	1	1	0	2	2	2	1	3
Socio-economic disadvantage (SEIFA)												
Mean SEIFA score	950	924	931	1030	1024	1026	1032	1006	1015	954	1044	999

Source: Ombudsman Western Australia

¹² Of children and young people who died between 1 July 2009 and 30 June 2018. The 2014 Investigation period commenced 1 July 2009 for a period of 3.5 years, and the 2020 Investigation period included a 5.5 year period ending 30 June 2018.

Table 5: Factors associated with suicide, for the 115 children and young people, by group and Ombudsman Investigation

Factors associated with suicide recorded	Group 1			Group 2			Group 3			Group 4		
	2014	2020	2009-10 to 2017-18 ¹³	2014	2020	2009-10 to 2017-18	2014	2020	2009-10 to 2017-18	2014	2020	2009-10 to 2017-18
Number of children and/or young people												
Children	0	10	10	0	0	0	0	1	1	0	0	0
Young People	20	40	60	5	12	17	6	11	17	5	5	10
TOTAL	20	50	70	5	12	17	6	12	18	5	5	10
Alleged experiences of abuse and/or neglect												
Neglect	12	37	49	0	0	0	0	0	0	0	0	0
Sexual abuse	9	22	31	0	0	0	0	0	0	0	0	0
Exposure to family and domestic violence	17	36	53	0	0	0	0	0	0	0	0	0
Physical abuse	8	23	31	0	0	0	0	0	0	0	0	0
Other emotional or psychological abuse	0	27	27	0	0	0	0	0	0	0	0	0
Mental health issues												
Diagnosed mental health condition	8	19	27	5 ¹⁴	7	12	0	0	0	0	0	0
Self-harm	11	20	31	4	3	7	0	2	2	0	0	0
Suicidal ideation and behaviour												
Ideation	13	30	43	5	8	13	2	4	6	3	1	4
Communicated intention to die by suicide	12	20	32	3	1	4	1	0	1	3	1	4
Previously attempted suicide	12	20	32	2	2	4	0	0	0	2	1	3
Adverse family experiences												
Parent with a mental health condition	10	18	28	3	4	7	0	0	0	0	0	0
Problematic parental drug or alcohol use	8	28	36	0	0	0	0	0	0	0	0	0
Parent imprisoned during child or young person's life	5	13	18	0	0	0	0	0	0	0	0	0
Family member, friend or person known to them who had died by suicide	6	8	14	0	2	2	0	0	0	0	0	0
Substance use (lifetime)												
Consumed alcohol	11	28	39	2	1	3	2	1	3	3	1	4
Consumed illicit drugs	9	25	34	1	1	2	0	1	1	1	1	2

Source: Ombudsman Western Australia

¹³ Of children and young people who died between 1 July 2009 and 30 June 2018. The 2014 Investigation period commenced 1 July 2009 for a period of 3.5 years, and the 2020 Investigation period included a 5.5. year period ending 30 June 2018.

¹⁴ Includes young people recorded as having demonstrated significant planning of their death.

5.4 Children who died by suicide

Tragically, as identified in the Ombudsman's Annual Reports and reported in the media,¹⁵ 11 children aged 10 to 13 years died by suicide in Western Australia during the 2020 Investigation.

As discussed in Chapter 3 of Volume 3, there are relatively few models for understanding and explaining suicide by children. The research literature indicates that:

- by the age of 6 to 7 years, two thirds of children understand the concept of dying and know that everyone dies at some point and cannot be 'reawakened or brought back to life with magic powers';¹⁶ and
- by 8 years of age, children have a thorough understanding of suicide and are capable of carrying it out.¹⁷

However, there is increasing acceptance in the child development and suicidality literature that 'the intent to cause self-harm or death is most important, regardless of the child's cognitive understanding of the lethality, finality or outcome of their actions'.¹⁸

Deaths by suicide in children are, however, significantly different from suicide by young people:

As the numbers of deaths are low, research is scant and with small numbers of case studies to draw upon, evidence is not solid. Efforts to extrapolate from what is known about adolescent suicide is not accurate or helpful as children and adolescents differ in relation to physical, sexual, cognitive and social development.¹⁹

In children, suicide attempts may be more likely to be impulsive, arising from feelings of 'sadness, confusion, anger, or problems with attention and hyperactivity'²⁰ or a 'wish to end their emotional pain'.²¹

¹⁵ Australian Broadcasting Corporation, 'Indigenous suicide inquest told rate of death's in WA's north has 'reached disturbing proportions', 26 June 2017, viewed 22 September 2018, <<http://www.abc.net.au/news/2017-06-26/indigenous-suicide-in-north-wa-unacceptable-inquest-told/8652118>>.

¹⁶ headspace School Support, Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary, <<https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res2.pdf>>, p. 5.

¹⁷ Centre for Suicide Prevention, Children and Suicide Resource Toolkit, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

¹⁸ headspace School Support, Understanding suicide, suicide attempts and self-harm in primary school aged children: Evidence Summary, <<https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res2.pdf>>, p. 5.

¹⁹ headspace, *Understanding suicide, suicide attempts and self-harm in primary school aged children*, viewed 28 February 2019, <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf>>, p. 1.

²⁰ American Academy of Child and Adolescent Psychiatry, 'Suicide in Children and Teens', June 2018, viewed 28 October 2019, <https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx>.

²¹ Centre for Suicide Prevention, Children and Suicide Resource Toolkit, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

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

- children (10 to 14 years), was 'characterised by higher prevalence of family conflicts, school related problems and suicides in social groups';
- young adults (20 to 24 years), involved a 'significantly higher prevalence of psychiatric disorders and were much more impacted by relationship problems'; and
- young people (15 to 19 years), demonstrated 'characteristics ... [that] fell in between the other age groups.'²²

Suicide attempts in childhood are also a major predictor of future suicide in later adolescence and adulthood,²³ with children who attempt suicide being 'up to six times more likely to attempt suicide again in adolescence.'²⁴

Eleven (14 per cent) of the 79 children and young people who died by suicide during the 2020 Investigation period were aged between 10 and 13 years at the time of their death (**the 11 children**). Ten of the 11 children allegedly experienced some form of child abuse or neglect that was reported to the Department of Communities, most commonly neglect (7 children, 64 per cent). A majority of the 11 children (8 children, 73 per cent) were recorded as having experienced multiple factors associated with suicide, as summarised in Figure 4:

Figure 4: Factors associated with suicide, for the 11 children

Young Person ID	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
37					
39					
50					
60					
61					
63					
68					
69					
72					
77					
107					

Factor experienced by a child who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

²² Kolves K and De Leo D, 'Child, Adolescent and Young Adult Suicides: A Comparison Based on the Queensland Suicide Registry', *Journal of Child and Adolescent Behavior*, vol. 209, no. 3, May 2015, doi:10.4172/2375-4494.1000209.

²³ Centre for Suicide Prevention, Children and Suicide Resource Toolkit, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

²⁴ Centre for Suicide Prevention, Children and Suicide Resource Toolkit, Canadian Mental Health Association, Calgary, February 2013, viewed 28 October 2019, <https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf>.

Contrary to the trend in older age groups, the majority of the 11 children who died by suicide (7 children, 64 per cent) were female. Additionally:

- 7 (64 per cent) were Aboriginal and four (36 per cent) were non-Aboriginal; and
- 5 (45 per cent) resided in a major city, two (18 per cent) resided in a regional area, and four (36 per cent) lived in a very remote region.

Ten of the 11 children were known to the Department of Communities in relation to alleged child abuse or neglect.

The research literature observes that:

The first 1000 days of a child's development (from conception to the end of a child's second year), and the early childhood years can be fundamental to a child's life successes. These early years are a unique period of opportunity when the foundations of optimum health, growth and neurodevelopment across the lifespan are developed. ...

Early intervention programs should focus on early childhood and the first 1000 days, with a focus on assisting new parents, families and schools.²⁵

For these reasons, together with the observations in Chapter 2 of Volume 3, regarding effective suicide prevention strategies for children and young people, the Ombudsman has made the following recommendation:

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

This suicide prevention plan for children and young people should:

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

²⁵ 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.

5.5 Aboriginal and/or Torres Strait Islander children and young people who died by suicide

5.5.1. Historical and contemporary context

Aboriginal and Torres Strait Islander culture is a significant protective force and strength for children and young people. There is a wealth of evidence demonstrating a positive correlation between health, education, wellbeing, employment outcomes, family functioning and safety for children and communities, with language and culture.²⁶

However, as observed in the *Bringing them home* report, the British 'invasion'²⁷ of Australia brought very rapid changes to Aboriginal and Torres Strait Islander societies and widespread forcible removal of Aboriginal children from their families, where these children were commoditised and viewed by Europeans primarily as a source of labour.²⁸

In Western Australia, Aboriginal children were removed from their mothers when they were about 4 years old, placed in dormitories, and then, at about 14 years old, sent to missions and settlements to work, under legislative powers granted to the 'Chief Protector'.²⁹

From approximately 1910 to 1970 'not one Indigenous family ... escaped the effects of forcible removal,'³⁰ and the ongoing legacy of these laws, policies and practices on Aboriginal and Torres Strait Islander peoples has created intergenerational trauma:

If people don't have an opportunity to heal from trauma, it continues to impact on the way they think and behave, which can lead to a range of negative outcomes including poor health, violence and substance abuse. This in turn leads to a vicious cycle of social and economic disadvantage.

Unknowingly, the trauma is often passed down to the next generation and then the next, which creates a ripple effect within families and communities. This is what we call Intergenerational Trauma. As the descendant population keeps growing, so will experiences with trauma and its many negative outcomes.³¹

²⁶ Lohar S, Butera N, and Kennedy E, Strengths of Australian Aboriginal cultural practices in family life and child rearing: Child and Family Community Australia Paper No. 25, Australian Institute of Family Studies, September 2014, viewed 21 March 2019, <<https://aifs.gov.au/cfca/publications/strengths-australian-aboriginal-cultural-practices-fam/export>>; House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, Commonwealth of Australia, Our Land Our Languages: Language Learning in Indigenous Communities, Canberra, September 2011; Lawrence R, Research on strong Indigenous communities, Brief 1, Indigenous Justice Clearinghouse, April 2007, viewed 21 March 2019, <<https://www.indigenousjustice.gov.au/wp-content/uploads/mp/files/publications/files/brief001.pdf>>.

²⁷ Australian Government Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 38.

²⁸ Australian Government Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 23.

²⁹ Australian Government Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 25.

³⁰ Australian Government Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, Human Rights and Equal Opportunity Commission, Sydney, 1997, p. 31.

³¹ Healing Foundation, New report sheds light on disadvantage for the Stolen Generations and their descendants, 2018, <https://www.healingfoundation.org.au/app/uploads/2018/09/Stolen_Generation_Demographic_Report_Factsheet_Jun2018_V7.pdf>, p. 4.

Collectively, the impact of these historical laws, policies and practices has resulted in what Justice Deane referred to as a 'legacy of unutterable shame'.³² This legacy of historically discriminatory policies and practices, and the long-term impacts of intergenerational trauma, continue to increase Aboriginal and Torres Strait Islander children and young people's vulnerability to poor health and wellbeing outcomes, as noted in the 2018 *Closing the Gap Prime Minister's Report*.³³

Aboriginal and Torres Strait Islander young people are also directly impacted by very high rates of psychological distress and exposure to life stressors. Aboriginal and Torres Strait Islander young people aged 15 to 19 years reported that the most common stressors are the death of a family member or friend (22 per cent); inability to get a job (22 per cent); serious illness (7 per cent); mental illness (7 per cent) and overcrowding at home (7 per cent).³⁴

Approximately 40,000 Aboriginal children and young people live in Western Australia, accounting for 40 per cent of the State's total Aboriginal population, and 6.8 per cent of the State's total population of children and young people.³⁵ While the majority of these children and young people meet or exceed all relevant developmental milestones, they are significantly over-represented in the out of home care and juvenile justice systems, comprising 66 per cent of the children and young people under youth justice supervision in Western Australia during 2015-2016 and 54 per cent of the children and young people in the care of the CEO of the Department of Communities in 2016-17.³⁶

Many Aboriginal and Torres Strait Islander children and young people are disproportionately exposed to grief, trauma, loss and discrimination which greatly affects their social and emotional wellbeing:³⁷

Many also experience a range of negative impacts associated with chronic economic disadvantage, lack of access to appropriate support services, ongoing discrimination by the criminal justice, limited educational and employment opportunities, loss of Elders and other adult family members and mentors due to early deaths or imprisonment'.³⁸

³² *Mabo and Others v. Queensland* (No. 2) [1992] HCA 23, per Deane and Gaudron JJ at [50].

³³ Department of the Prime Minister and Cabinet, Australian Government, *Closing the Gap: Prime Minister's Report 2018*, DPC, Canberra, 2018, pp. 9, 38, 53, 76, 104 and 120.

³⁴ Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018: in brief*, AIHW, Canberra, 2018.

³⁵ Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2016', *Estimates of Aboriginal and Torres Strait Islander Australians*, June 2016, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.

³⁶ KidsMatter, *Aboriginal infants and children: supporting and promoting their wellbeing and development*, Telethon Kids Institute, Perth, 2010, p. 4; Commissioner for Children and Young People Western Australia, *Profile of Children and Young People in WA*, November 2017, p. 20; Department of Communities, *Additional Performance Information: Final Report 2016-2017*, Department of Communities, 2017, p. 11.

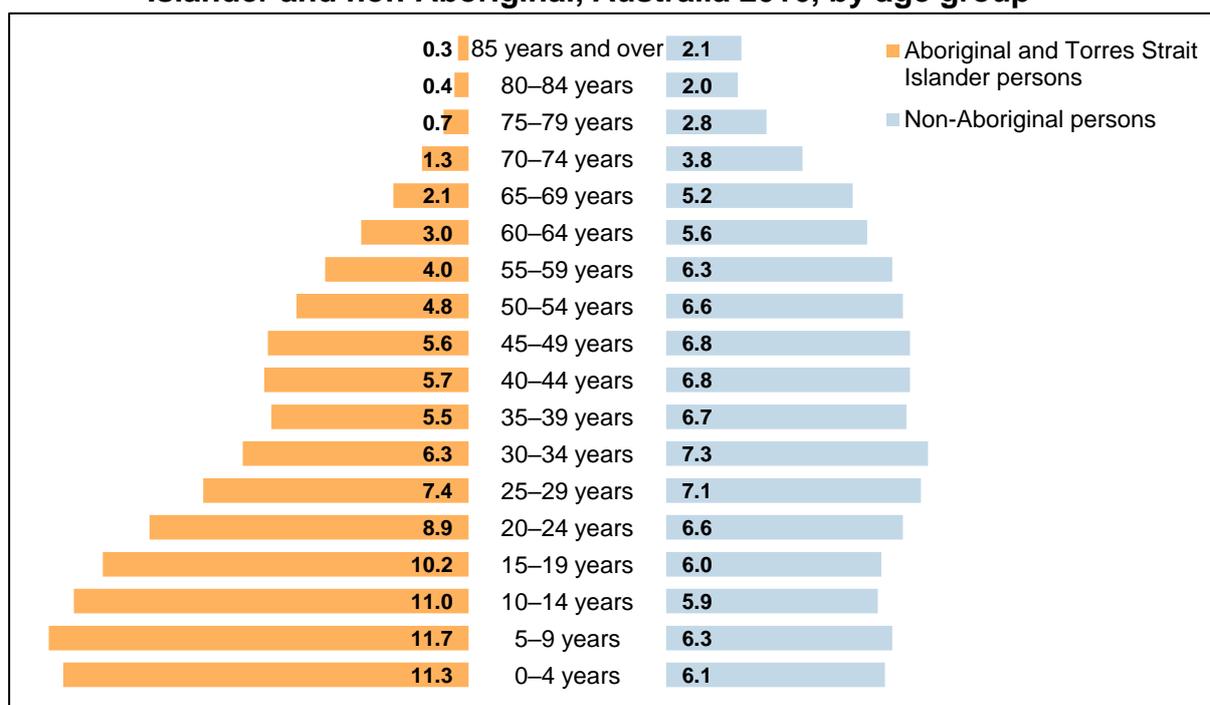
³⁷ Chalmers KJ et al, 'Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus guidelines', *International Journal of Mental Health Systems*, vol. 8, no. 6, 2014, citing Zubrick S et al, *The Western Australian Aboriginal child health survey: the social and emotional wellbeing of Aboriginal children and young people*, Technical Report, July 2005.

³⁸ Scrine C et al, *Suicide prevention for Aboriginal and Torres Strait Islander young people: Fact Sheet 3 for the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*, Telethon Kids Institute and the University of Western Australia, Perth, 2015 viewed 22 March 2019, <<https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/natsispep/fact-sheet-no-3.pdf>>, p. 1, citing Higgins D and Davis K, *Law and justice: prevention and early intervention programs for Indigenous youth*, Resource sheet no. 34, Closing the Gap Clearinghouse, Canberra.

5.5.2. Age

The Aboriginal and/or Torres Strait Islander population has a significantly different age distribution to the normally distributed population of non-Aboriginal and/or Torres Strait Islander people due to higher fertility and mortality rates,³⁹ meaning that the population has a larger proportion of younger people and fewer older people, when compared to the non-Aboriginal population, as shown in Figure 5.

Figure 5: Population distribution, Aboriginal and/or Torres Strait Islander and non-Aboriginal, Australia 2016, by age group⁴⁰



Source: ABS⁴¹ and Ombudsman Western Australia

Healthy communities need an adequate number of healthy adults to care for the next generation. When considered in the context of Aboriginal and/or Torres Strait Islander peoples' experiences of poorer health, higher rates of disability, significantly higher rates of imprisonment and child removal, increased rates of substance misuse, exposure to more traumatic events and lower household incomes than the general population, the number of adults that are available to care for children is dramatically impacted.⁴² This means that, often, children and young people themselves are burdened with care responsibilities for siblings, or parents with health issues, disability or substance misuse issues.

However, it is important to acknowledge that, in the face of these challenges, Aboriginal and/or Torres Strait Islander 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

³⁹ Australian Institute of Health and Welfare, Australian Government, 'The Indigenous population key points', *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015*, AIHW, Canberra, 9 June 2015.

⁴⁰ Australian Bureau of Statistics, 'Introduction', *Census of Population and Housing: Estimating homelessness*, cat. no. 2049.0, ABS, Canberra, 14 March 2018.

⁴¹ Australian Bureau of Statistics, *Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016 – Aboriginal and Torres Strait Islander Population*, cat. no. 2071.0, ABS, Canberra, 20 March 2018.

⁴² Department of Health, Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, 27 June 2013, viewed 6 May 2019, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc~priorities~whole-life>>.

achieve social and economic equity for their communities through self-determination and culturally informed solutions.

5.6 Patterns in the characteristics of the Aboriginal and Torres Strait Islander children and young people who died by suicide

Historically, suicide by Aboriginal people was extremely rare and 'almost unheard of prior to the 1960s.'⁴³ Beginning in the 1980s, the number of Aboriginal people who died by suicide began to increase, a trend that has continued over the past 30 years.

In the 5 years from 2013 to 2017, suicide was the leading cause of death for Aboriginal and/or Torres Strait Islander people aged between 15 and 34 years of age, and was the second leading cause of death for Aboriginal and/or Torres Strait Islander people aged between 1 and 14 years of age.⁴⁴ Further, Aboriginal and/or Torres Strait Islander children and young people accounted for more than a quarter of all suicide deaths among Australian children and young people aged between 5 and 17 years of age (93 of the 358 deaths, 26 per cent).⁴⁵

Forty three of the 115 children and young people were recorded as identifying as Aboriginal or Torres Strait Islander. This significant over-representation is reflective of higher rates of suicide for Indigenous peoples across the world⁴⁶ and for Aboriginal and/or Torres Strait Islander people as compared to the non-Aboriginal Australian population.⁴⁷

Aboriginal and/or Torres Strait Islander children and young people face different risk factors to the non-Aboriginal population as a result of the ongoing impact of past government laws, policies and practices, namely:

- stress associated with bullying, harassment, peer rejection, failure and disengagement at school and stress associated with family violence, overcrowding, poverty, and alcohol and cannabis misuse in the household;⁴⁸
- high levels of stress and isolation arising from their roles as carers of parents and siblings with mental illness or disability;⁴⁹ and
- racism, which has been shown to exacerbate mental health issues, negate the protective effects of parenting and family function, limit the capacity of parents to promote child development and access culturally appropriate supports for their family, and is

⁴³ Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, p. 6, citing Hunter E and Milroy H, 'Aboriginal and Torres Strait Islander Suicide in Context', *Archives of Suicide Research*, vol. 10, pp. 141-157.

⁴⁴ Australian Bureau of Statistics, 'Table 11.4 – Intentional self-harm by Indigenous status', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

⁴⁵ Australian Bureau of Statistics, 'Table 11.12 – Intentional self-harm, Number of deaths in children aged 5-17 years by Aboriginal and Torres Strait Islander status, NSW, Qld, SA, WA and NT, 2013-2017', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018.

⁴⁶ World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 36.

⁴⁷ Australian Bureau of Statistics, 'Table 11.4 – Intentional self-harm by Indigenous status', *Causes of Death, 2017*, cat no. 3303.0, ABS, Canberra, September 2018. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

⁴⁸ ATSIPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>.

⁴⁹ ATSIPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>.

associated with poor physical and mental health and negative social and emotional wellbeing of children (including anxiety, depression, low self-esteem, suicide and self-harm).⁵⁰

5.6.1. Age and sex

Unlike non-Aboriginal children and young people who died by suicide, male and female Aboriginal and Torres Strait Islander children and young people died by suicide at approximately equal prevalence. Twenty-two were male (51 per cent) and 21 were female (49 per cent). By comparison, among the 72 non-Aboriginal children and young people who died by suicide, 50 were male (69 per cent) and 22 were female (31 per cent).

The Office identified that all of the 43 Aboriginal and Torres Strait Islander children and young people (81 per cent) were recorded as having experienced one or more factors associated with suicide, including:

- 36 of the 43 (84 per cent) Aboriginal and Torres Strait Islander children and young people were recorded as having allegedly experienced some form of child abuse or neglect that was reported to the Department of Communities; and
- 35 of the 43 (81 per cent) Aboriginal and Torres Strait Islander children and young people were recorded as having allegedly experienced child abuse or neglect in conjunction with other factors associated with suicide, including suicidal behaviour and ideation (24 children and young people, 50 per cent), mental health issues (19 children and young people, 44 per cent), substance use (27 children and young people, 63 per cent) and adverse family experiences (32 children and young people, 74 per cent).

5.6.2. Resilience factors

The research literature however also identifies many strengths which have allowed Aboriginal and/or Torres Strait Islander children and young people to be resilient, survive and thrive in the face of such high levels of adversity, including:

- strong cultural identity and belief systems
- extensive kinship systems which are socially inclusive
- broader attachment models
- cultural and spiritual strengths including connection to country and ancestry
- strong child rearing practices
- early autonomy and self-reliance
- cultural ways of learning
- role of traditional healers and ceremony
- focus on healing.⁵¹

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (**ATSISPEP**) identified that the key to preventing suicide by Aboriginal children and young people is:

... growing up in a healthy, safe, supportive environment, with a strong connection to culture, community and school ... It is critically important that we gain a better understanding of the cumulative and complex impact of stress exposures over the life-course to ensure appropriate preventative responses and

⁵⁰ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf>.

⁵¹ Healing Foundation, *Working with Aboriginal and Torres Strait Islander young people and their families*, viewed 2 April 2019, <<https://healingfoundation.org.au/app/uploads/2018/07/HF-Young-People-fact-sheet.pdf>>.

address the negative trajectory of suicidal behaviour, which can start at a young age.

This will be facilitated in part by enhancing and increasing the number of appropriate services and programs to support families and children. It is important that all Indigenous children have access to the supports and strategies offered by early child care that help them build coping skills, resilience and self-regulation from a young age. ...

Adequate follow up care to children at risk and monitoring any attempt at self-harm is critical, as well as ensuring access to appropriate services and strategies to foster help-seeking behaviour among Indigenous children.⁵²

5.6.3. Region of residence

A higher number of Aboriginal and Torres Strait Islander children and young people died by suicide in remote and very remote areas. However, this does not indicate that all Aboriginal and Torres Strait Islander children and young people living in a remote or very remote area are at increased risk of suicide by virtue of this factor alone. Of the 26 Aboriginal and Torres Strait Islander children and young people who died by suicide and lived in a remote or very remote area, 10 individual remote Aboriginal communities were identified, representing only 4 per cent of the 274 remote Aboriginal communities in Western Australia.

Canadian researchers who mapped deaths by suicide in all 197 First Nations communities in British Columbia, found that communities which had achieved the following markers of cultural continuity, experienced no cases of suicide by First Nations children and young people:

- self-government;⁵³
- land rights litigation;⁵⁴
- local control over health, education, and police services;⁵⁵ and
- operation of cultural facilities.⁵⁶

In communities that had not achieved any of the above protective markers, youth suicide rates were reported to be up to 800 times greater than the average.⁵⁷ The factors associated with suicide experienced by the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide are summarised in Figure 6.

⁵² ATSIPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, p. 2.

⁵³ Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.

⁵⁴ Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.

⁵⁵ Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.

⁵⁶ Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.

⁵⁷ Chandler M and Lalonde C, 'Cultural Continuity as a Hedge Against Suicide in Canada's First Nations', *Transcultural Psychiatry*, vol. 35, no. 2, June 1998, pp. 191-219.

Figure 6: Factors associated with suicide, for the 43 Aboriginal and Torres Strait Islander children and young people, by Ombudsman Investigation

Child or young person	Suicidal behaviour and ideation	Substance use	Adverse family experiences	Child abuse or neglect	Mental health issues
1					
2					
5					
6					
11					
14					
16					
17					
18					
19					
34					
35					
36					
38					
39					
40					
41					
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61					
62					
63					
67					
68					
69					
70					
71					
77					
78					
82					
83					
84					
105					
112					
115					

Factor experienced by an Aboriginal or Torres Strait Islander young person who died by suicide during the 2014 Investigation Period

Factor experienced by an Aboriginal or Torres Strait Islander child or young person who died by suicide during the 2020 Investigation Period

Source: Ombudsman Western Australia

ATSISPEP's *Real Time Suicide Data: A Discussion Paper* identifies the 'variable quality of Aboriginal and Torres Strait Islander identification at the State and national levels, resulting in an unexpected under-reporting'⁵⁸ of Aboriginal and Torres Strait Islander people who died by suicide.

During the 2020 investigation, the Office considered child death review notifications received by the Ombudsman and identified that a significant proportion of the child death notifications received each year state that a child or young person's Aboriginal or Torres Strait Islander status is 'unknown', as shown in the Ombudsman Western Australia *Annual Report 2018-19*.

Table 6: Number of child death review notifications received, 2009-10 to 2018-19, by year and recorded Aboriginal and Torres Strait Islander status

Year	Aboriginal and/or Torres Strait Islander	Non-Aboriginal	Unknown	Total Notifications	Percentage of notifications received with 'unknown' Aboriginal status
2009-10	18	38	20	76	26%
2010-11	24	61	33	118	28%
2011-12	25	35	23	83	28%
2012-13	26	31	49	106	46%
2013-14	16	20	34	70	49%
2014-15	20	32	32	84	38%
2015-16	21	39	24	84	29%
2016-17	26	43	20	89	22%
2017-18	18	29	26	73	36%
2018-19	18	23	37	78	47%

Source: Ombudsman Western Australia

The Office also observed inconsistencies in the recording of Aboriginal and Torres Strait Islander identity of the 43 Aboriginal and Torres Strait Islander children and young people who died by suicide. These inconsistencies occurred:

- between State government departments and authorities;
- within the records of individual agencies;
- during children and young people's lives; and
- after their deaths by suicide.

The first step in providing culturally appropriate services to Aboriginal and Torres Strait Islander children and young people is asking questions of cultural identity,⁵⁹ and understanding the community's 'language, traditions and customs and family and

⁵⁸ Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 2.

⁵⁹ Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 3.

community obligations'⁶⁰ Accordingly, it is important for State government departments and authorities to work collaboratively in sharing and recording the Aboriginal and Torres Strait Islander status of children and young people.

The Ombudsman has made the following recommendations:

Recommendation 2: That, further to Recommendation 1, the Mental Health Commission develop (as an adjunct to the State suicide prevention plan for children and young people) a separate suicide prevention plan for Aboriginal children and young people, given the special vulnerability and overrepresentation of Aboriginal children and young people in the number of deaths by suicide and hospital admissions and emergency department attendances for self-harm and suicidal behaviour.

Recommendation 3: That the Mental Health Commission, Department of Health, Department of Communities and Department of Education:

- work collaboratively with each other and Aboriginal and Torres Strait Islander people to identify culturally safe ways to ask questions about cultural identity in situations where there are concerns about a child or young person's self-harming or suicidal behaviour; and
- proactively share this information when multiple agencies are working with a child, young person, or their family, in order to provide culturally informed services and care.

⁶⁰ Gordon, S, Hallahan, K, and Henry D, Putting the picture together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, Department of Premier and Cabinet, Perth, 2002, p. 360.

6. Self-harm by children and young people in Western Australia

The 2020 Investigation found that previous self-harming or suicidal behaviour was prevalent among the 115 children and young people, with records indicating that, prior to their death:

- 66 of the 115 children and young people (57 per cent) experienced suicidal ideation;
- 41 of the 115 children and young people (36 per cent) communicated suicidal intent;
- 40 of the 115 children and young people (35 per cent) self-harmed; and
- 39 of the 115 children and young people (34 per cent) previously attempted suicide.

The 2020 Investigation also identifies and draws upon research literature conceptualising deaths by suicide as the highly visible tip of an 'iceberg' model of suicidal and self-harming behaviour which 'conveys the hierarchical yet dynamic nature of self-harm'⁶¹ in the community.

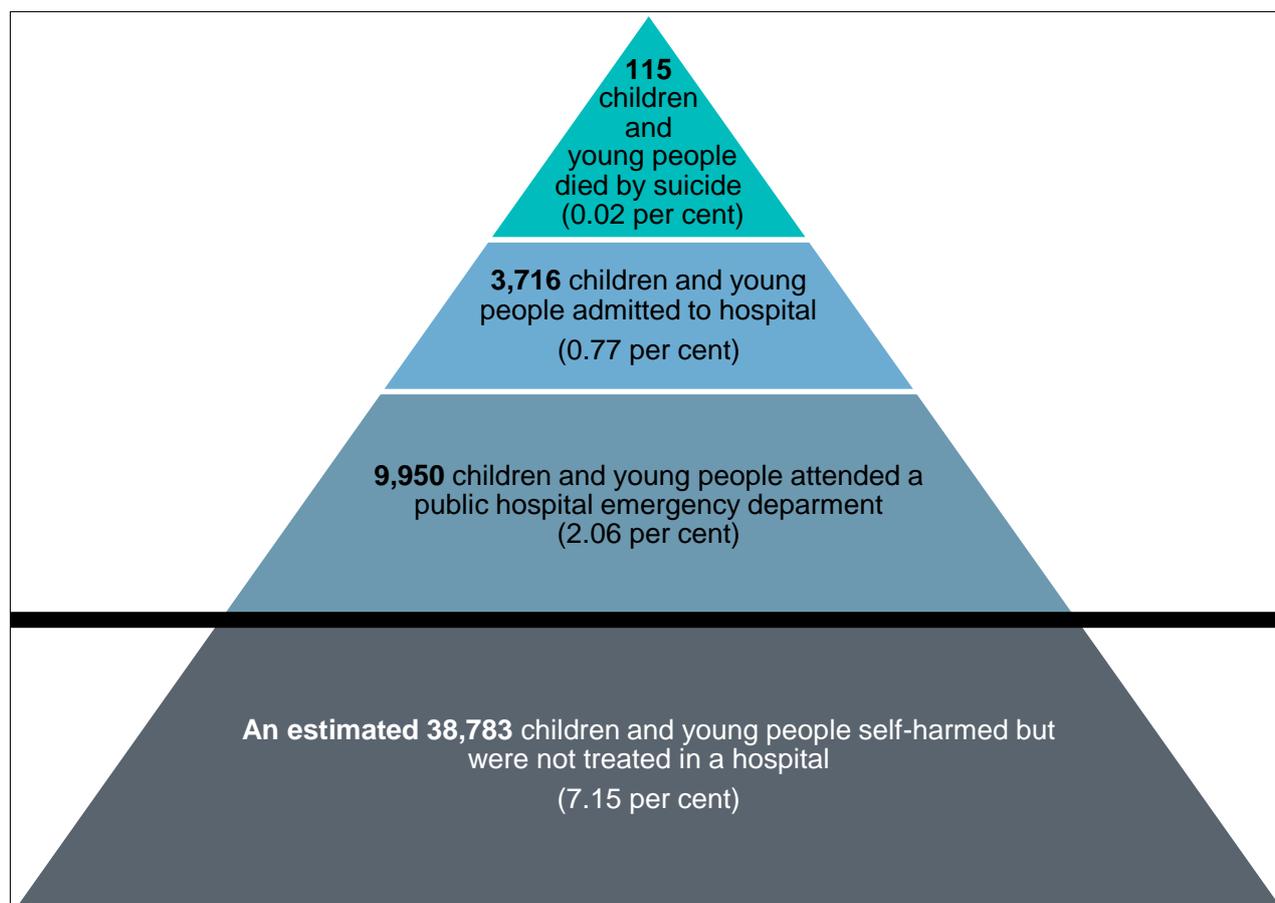
For the first time in Western Australia, the 2020 Investigation estimates the extent of suicidal and self-harming behaviour among Western Australian children and young people over the 9 year period from 1 July 2009 – 30 June 2018 utilising:

- ABS population data;
- hospital admission and emergency department attendance data from public hospitals; and
- published community survey data, including data from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing.⁶²

⁶¹ G Geulayov et al, 'Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study', *The Lancet Psychiatry*, vol. 5 no. 2, p. 167-174.

⁶² Lawrence D et al, *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Department of Health, Canberra, 2015.

Figure 7: Suicide and self-harm by children and young people in Western Australia, 1 July 2009 – 30 June 2018



Source: Ombudsman Western Australia

The research literature also identifies that 'long-term monitoring of the incidence, demographic patterns and methods involved in cases of attempted suicide and self-harm presenting at hospitals in a country or region provides important information that can assist in the development of suicide prevention strategies.'⁶³

Accordingly, given the continued prevalence of this trend of self-harming and suicidal behaviour in children and young people who died by suicide, the Office obtained data from the Department of Health relating to hospital admissions and emergency department attendances for non-fatal intentional self-harm. Chapter 4 of Volume 3 considers the characteristics of the children and young people who were admitted to hospital or attended an emergency department for self-harm in Western Australia between 1 July 2009 and 30 June 2018.

⁶³ World Health Organization, *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*, WHO, Geneva, 2016, p. 6.

6.1 Hospital admissions for self-harm by children and young people

6.1.1. Circumstances of admission

There were 3,716 children and young people between the ages of 6 and 17 years, admitted to hospital on 5,142 occasions⁶⁴ for self-harm in Western Australia from 1 July 2009 to 30 June 2018. The highest number of individual children and young people over the 9 year period was 571 in 2012-13 with the lowest in 2009-10 (333 children and young people).

The number of hospital admissions for self-harm over the 9 years varied from 411 in 2009-10 to 672 in 2017-18. The highest number of admissions in one year was in 2012-13 when there were 790 admissions for self-harm.

The majority of hospital admissions for self-harm by children and young people were due to intentional self-poisoning (3,467 admissions or 67 per cent).

In 22 per cent of the 5,142 admissions, children and young people were recorded as having a principal diagnosis of paracetamol toxicity (1,128 admissions or 33 per cent of poisonings). The second most frequent principal diagnosis was poisoning by antipsychotic and neuroleptic drugs (461 admissions or 9 per cent), followed by other and unspecified antipsychotic and neuroleptic drugs (211 admissions, 4 per cent). Acute stress reactions accounted for 210 primary diagnoses for the children and young people (210 admissions, 4 per cent).

In non-poisoning admissions, contact with a sharp object was the most common mechanism of self-harm, comprising 22 per cent (1,141) of total admissions of children and young people.

Where admission records specified a place of occurrence for a child or young person's self-harming behaviours, the majority occurred within the home (56 per cent or 1,576 of the 3,071 admissions with a location recorded). Health service areas (461 admissions, 15 per cent), bedrooms (171 admissions, 6 per cent) and school (131 admissions, 5 per cent) were the other most frequently disclosed locations for children and young people to self-harm.

On average, the duration of hospital stays for children and young people admitted to hospital for self-harm was four days. The duration of these hospital admissions ranged from less than one day to 317 days.

6.1.2. Characteristics of children and young people admitted

Age and sex

Between 2009-10 and 2017-18, 367 children aged 6 to 13 years and 3,349 young people aged 14 to 17 years were admitted to hospital for self-harm and/or suicidal behaviours for the first time. These 3,716 children and young people were 0.8 per cent of the total population of individual children and young people aged 6 to 17 years in WA over the same period (482,285). The average age of children and young people hospitalised in Western Australia due to self-harm was 15 years 6 months, at the time of their first admission. Three quarters (75 per cent) of hospital admissions due to self-harm among children and young people were for young people aged between 15 and 17.

⁶⁴ That is, admissions where the ICD-10 external cause code was X60-X84 or Y87.

The number of hospital admissions due to self-harm increased for most age groups between 2009-10 and 2017-18. Fifteen year old young people demonstrated the largest increase.

Most hospital admissions were for female children and young people. Of the 5,142 hospital admissions due to self-harm, 4,167 (81 per cent) were female children and young people and 975 (19 per cent) were male. Similarly, of the 3,716 individual children and young people hospitalised due to self-harm, 2,935 (79 per cent) were female and 781 (21 per cent) were male.

The higher frequency of female children and young peoples' admission to hospital for self-harm was consistent across every age group, except children aged under 11 years (where 18 male children were admitted on 18 occasions, compared to 12 female children).

The age-specific rate for children and young people aged 6 to 17 years remained relatively stable amongst males, however increased by 54 per cent for female children and young people. This has led to an increased rate of hospital admissions for self-harm in the 6 to 17 years age group, from 94.8 children and young people hospitalised per 100,000 in 2009-10 to 133.5 per 100,000 in 2017-18 (41 per cent).

Region of residence

Most children and young people admitted to hospital for self-harm were from the Perth metropolitan area (2,566 children and young people, or 69 per cent). These children and young people also accounted for the majority of admissions (3,726 or 72 per cent).

Children and young people from regional and remote areas were over-represented when compared to the proportion of the Western Australian children and young people living in these regions. A total of 1,146 children and young people from regional and remote areas were admitted to hospital for self-harm (31 per cent) and were admitted to hospital on 1,379 occasions.

Aboriginal and/or Torres Strait Islander children and young people

Aboriginal and/or Torres Strait Islander children and young people were over-represented among the admissions for self-harm, when compared to the Western Australian 6 to 17 years population. A total of 327 Aboriginal and/or Torres Strait Islander children and young people (9 per cent) were admitted to hospital for self-harm on 389 occasions (8 per cent of all admissions). By way of comparison, Aboriginal and/or Torres Strait Islander children and young people make up 7 per cent of the child and young person population in Western Australia.

The number of hospital admissions for self-harm among Aboriginal and/or Torres Strait Islander children and young people increased from 26 (of 411 admissions, 6 per cent) in 2009-10 to 59 (of 672 admissions, 9 per cent) in 2017-18.

Duration of hospital stay

The majority of children and young people (80 per cent) admitted to hospital in relation to self-harm spent up to three days in hospital prior to separation from the hospital. Four per cent of the children and young people admitted to hospital for self-harm remained in hospital for more than 14 days.

Repeated hospital admissions

Most children and young people (2,976 children and young people, 80 per cent) were admitted to hospital for self-harm only once between 2009-10 to 2017-18. A small number (85 children and young people, 2 per cent) were admitted on five or more occasions, accounting for 600 admissions or 12 per cent.

6.2 Emergency department attendances for self-harm and suicidal ideation by children and young people in Western Australia

The Office obtained data for each emergency department attendance by a child or young person between 1 July 2009 to 30 June 2018 where the recorded diagnosis⁶⁵ related to self-harm or suicidal ideation.

The data excludes children and young people that:

- died in the emergency department;
- were discharged from an emergency department and admitted to hospital on the same day; and
- were aged under 6 years.

Some variation in this emergency department attendance data over time is attributable to improvements in data collection practices. Particularly in regional and remote hospitals where emergency department attendance data has only been consistently captured as part of the Department of Health's Emergency Department Data Collection since the start of the 2016-17 financial year.

There were a total of 9,950 individual children and young people who attended an emergency department with a recorded diagnosis relating to self-harm between 1 July 2009 and 30 June 2018. These 9,950 children and young people attended an emergency department on 17,115 occasions between 1 July 2009 and 30 June 2018 for self-harm.

The number of emergency department attendances for self-harm by children and young people has increased from 830 in 2009-10 to 3,362 in 2017-18.

6.2.1. Circumstances of emergency department attendance

The majority of emergency department attendances for self-harm by children and young people (71 per cent) were of less than one day prior to discharge.

⁶⁵ In the Department of Health Emergency Department Data Collection, this field is named 'episode diagnosis'.

6.2.2. Characteristics of the children and young people who presented to emergency departments

Age

The average age of children and young people who attended an emergency department with a recorded diagnosis related to self-harm was 15 years. Similarly, most admissions (11,420) and most patients (6,583) were young people between the ages of 15 to 17 years of age. The number of emergency department attendances for self-harm by 15 to 17 year olds has increased, from 533 in 2009-10 to 2,278 in 2017-18. However, emergency department attendances by children aged between 6 and 13 have also increased over the 9 year period, from a total of 148 attendances in 2009-10 to 617 in 2017-18.

Sex

Consistent with trends in the hospital admission of children and young people for self-harm and suicidal ideation and behaviour, female children and young people constituted most of the emergency department attendances. Of the 9,950 individual children and young people who attended an emergency department for self-harm and whose sex was recorded:

- 6,532 (66 per cent) were female; and
- 3,414 (34 per cent) were male.

However, female children and young people did not attend emergency departments for self-harm at a higher rate across all ages. The Office's analysis indicates that:

- up until the age of 11, male children attended an emergency department at a higher rate than female children; and
- from the age of 12, emergency department attendances by female children and young people increased and exceeded the number of emergency department attendances by males at each age from 12 to 17.

Region of residence

In 2017-18, most children and young people who attended an emergency department for self-harm resided in the Perth metropolitan area (8,054 of 9,950 children and young people, or 83 per cent). However, children and young people from remote and very remote areas were overrepresented as a proportion of emergency department attendances for self-harm, despite incomplete data for the 2009 to 2016 period for these areas.

Aboriginal and/or Torres Strait Islander children and young people

The number of emergency department attendances for self-harm among Aboriginal and/or Torres Strait Islander children and young people increased from 77 in 2009-10 to 399 in 2017-18.

In 2017-18, 14 per cent of the individual children and young people who attended an emergency department for self-harm were Aboriginal and/or Torres Strait Islander. By comparison, Aboriginal and/or Torres Strait Islander children and young people made up an estimated 7 per cent of the population of children and young people in Western Australia in June 2016.⁶⁶

Repeated emergency department attendances

The majority of the 9,950 children and young people attended an emergency department for self-harm only once between 2009-10 and 2017-18 (6,990 children and young people, 70 per cent).

Significantly, however, 289 children and young people attended an emergency department for treatment relating to self-harm on more than five occasions. This small proportion of children and young people (3 per cent) attended an emergency department on a combined 3,323 occasions (19 per cent).

7. Factors associated with suicide by children and young people

There is no simple explanation for suicide, as it occurs within a complex context of inter-related biological, psychological, social and environmental factors.⁶⁷ However, as identified in the research literature:

- 'there is no set of risk factors that can accurately predict suicide in the individual patient',⁶⁸ and
- the 'risk of suicide is dynamic and can change rapidly. Risk assessments are limited to a 'snapshot' of presenting issues which are sensitive to triggers in the environment as well as current individual presentation.'⁶⁹

The research literature also identifies that there are significant differences in the observed risk factors and precipitating events prior to suicide by children,⁷⁰ young people,⁷¹ and adults⁷² including:

⁶⁶ Australian Bureau of Statistics, 'Table 5: Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, Western Australia, single year of age (to 65 and over) - 30 June 2018', *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016, cat. no. 3238.0.55.001, ABS, Canberra, August 2018.*

⁶⁷ Mendoza J and Rosenberg S, *Suicide and Suicide Prevention in Australia: Breaking the Silence*, Lifeline Australia and Suicide Prevention Australia, 2010, p. 54.

⁶⁸ Department of Health, *Principles and Best Practice for the Care of People Who May Be Suicidal*, Government of Western Australia, Perth, 2017, p. 2.

⁶⁹ Department of Education, *School Response and Planning Guidelines for Students with Suicidal Behavior and Non-Suicidal Self Injury*, Government of Western Australia, Perth, 2018, p. 27.

⁷⁰ Headspace, *Understanding suicide, suicide attempts and self-harm in primary school aged children*, viewed 28 February 2019, <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf?>>, p. 1.

⁷¹ Parellada M et al, 'Is attempted suicide different in adolescent and adults?', *Psychiatry Research*, vol. 157, 2008, pp. 131-137.

⁷² Parellada M et al, 'Is attempted suicide different in adolescent and adults?', *Psychiatry Research*, vol. 157, 2008, pp. 131-137.

- their physical, sexual, cognitive and social development;⁷³
- impulsivity;⁷⁴
- pathways to suicide;⁷⁵
- rates of identified depression or mental illness prior to death;⁷⁶ and
- the types of relationship problems most commonly experienced prior to death.⁷⁷

Accordingly, population-level awareness of the factors associated with suicide by children and young people in Western Australia, may assist in designing programs and services to better meet the needs of vulnerable children and young people who are at risk of suicide.

The research literature identifies groups of children and young people that have relatively high rates of suicide. However, the research literature also acknowledges that some of these children and young people 'are not intrinsically more at risk of suicidal behaviour'.⁷⁸ Rather, these groups may more frequently 'experience ... discrimination, isolation and other forms of social exclusion which can impact on suicidal thinking and behaviour'. Other children and young people 'may be at increased risk of suicide due to their experiences (in childhood or adulthood), their current access to economic and social resources, their current health status and their previous exposure to suicidal behaviour'.⁷⁹

These groups include:

- children and young people who have previously attempted suicide;⁸⁰
- children and young people who have experienced abuse or neglect;⁸¹

⁷³ headspace, *Understanding suicide, suicide attempts and self-harm in primary school aged children*, viewed 28 February 2019, <https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf?>>, p. 1.

⁷⁴ Parellada M et al, 'Is attempted suicide different in adolescent and adults?', *Psychiatry Research*, vol. 157, 2008, pp. 131-137.

⁷⁵ BoysTown, *Preventing Suicide by Young People: Discussion Paper*, BoysTown and Kids Helpline, October 2015, p. 1; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people*, University of Manchester, Manchester, July 2017, p. 21.

⁷⁶ Sheftall AH et al, 'Suicide in Elementary School-Aged Children and Early Adolescents', *Journal of the American Academy of Pediatrics*, vol. 138, no. 4, October 2016: e20160436

⁷⁷ Sheftall AH et al, 'Suicide in Elementary School-Aged Children and Early Adolescents', *Journal of the American Academy of Pediatrics*, vol. 138, no. 4, October 2016: e20160436; Kolves K and De Leo D, 'Child, Adolescent and Young Adult Suicides: A Comparison Based on the Queensland Suicide Registry', *Journal of Child and Adolescent Behavior*, vol. 209, no. 3, May 2015, doi:10.4172/2375-4494.1000209.

⁷⁸ Everymind, *Suicide Prevention – Understanding Suicide: Key facts*, Everymind, Newcastle, 2018, viewed 26 September 2018, <<https://everymind.org.au/suicide-prevention/understanding-suicide/key-facts>>.

⁷⁹ Everymind, *Suicide Prevention – Understanding Suicide: Key facts*, Everymind, Newcastle, 2018, viewed 26 September 2018, <<https://everymind.org.au/suicide-prevention/understanding-suicide/key-facts>>.

⁸⁰ beyondblue, *Risk factors for suicide*, viewed 13 September 2018, <<https://healthyfamilies.beyondblue.org.au/age-13/mental-health-conditions-in-young-people/suicide/risk-factors-for-suicide>>.

⁸¹ Brodsky B and Stanley B, 'Adverse childhood experiences and suicidal behavior', *Psychiatric Clinics of North America*, vol. 31, no. 2, June 2008, doi: 10.1016/j.psc.2008.02.002, pp. 223-235; Evans E, Hawton K, and Rodham K, 'Suicidal phenomena and abuse in adolescents: A review of epidemiological studies', *Child Abuse and Neglect*, vol. 29, no. 1, January 2005, doi: 10.1016/j.chiabu.2004.06.014, pp. 45-58; Miller AB et al, 'The relation between child maltreatment and adolescent suicidal behavior: A systematic review and critical examination of the literature', *Clinical Child and Family Psychology Review*, vol. 16, no. 2, June 2013, doi: 10.1007/s10567-013-0131-5, pp. 146-172; Thompson R et al, 'Adverse experiences and suicidal ideation in adolescence: Exploring the link using the LONGSCAN samples', *Psychology of Violence*, vol. 2, no. 2, April 2012, doi: 10.1037/a0027107, pp. 211-225.

- children and young people who have a mental illness;⁸²
- children and young people who know a person who died by suicide;⁸³
- Aboriginal and/or Torres Strait Islander children and young people;⁸⁴
- children and young people living in rural and remote areas;⁸⁵
- male children and young people;⁸⁶ and
- young people with diverse gender identity or sexuality.⁸⁷

In this report, as in the 2014 Investigation, we refer to these risk factors, warning signs and precipitating events as **factors associated with suicide**. The demographic characteristics and factors associated with suicide discussed in this report are shown at Figure 8.

⁸² Rodway C et al, 'Suicide in children and young people in England: a consecutive case series', *Lancet Psychiatry*, vol. 3, no. 8, 1 August 2016, pp. 751-759; Fleischmann A et al, 'Completed Suicide and Psychiatric Diagnoses in Young People: A Critical Examination of the Evidence', *American Journal of Orthopsychiatry*, vol. 75, no. 4, 2005, pp. 676-683.

⁸³ De Leo D and Heller T, 'Social modelling in the transmission of suicidality', *Crisis, the Journal of Crisis Intervention and Suicide*, vol. 29, no. 1, 2008, pp. 11-19; Commission for Children and Young People and Child Guardian, *Reducing youth suicide in Queensland Discussion Paper*, Queensland Government, Brisbane, 2009; Child Death Review Unit, *Looking for something to look forward to, A five-year retrospective review of child and youth suicide in BC*, British Columbia Coroners Service, 2008.

⁸⁴ The Australian Bureau of Statistics refers to 'Aboriginal and Torres Strait Islander peoples' and 'non-Indigenous' people.

⁸⁵ Australian Bureau of Statistics, 'Table 11.13 Intentional self-harm, Age specific death rates, 10 year age groups by sex, 2007-2016', *Causes of Death, Australia, 2016*, cat. no. 3303.0, ABS, Canberra, September 2017.

⁸⁶ Using rates calculated from the number of deaths by suicide analysed in the 2020 investigation and Australian Bureau of Statistics, 'Table 55 Estimated Resident Population By Single Year of Age, Western Australia', *Australian Demographic Statistics*, cat. no. 3101.0, ABS, Canberra, December 2018.

⁸⁷ King M et al., 'A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people', *BMC Psychiatry*, vol. 8, no. 70, August 2008, doi: 10.1186/1471-244X-8-70; Chakraborty A et al, 'Mental health of the non-heterosexual population of England', *British Journal of Psychiatry*, vol. 198, no. 2, February 2011, doi: 10.1192/bjp.bp.110.082271, pp. 143-148.

Figure 8: Demographic characteristics and factors associated with suicide, discussed in this report

Demographic characteristics	
<ul style="list-style-type: none"> • Age • Sex • Country of birth 	<ul style="list-style-type: none"> • Aboriginal status⁸⁸ • Region of residence • Experience of homelessness
Factors associated with suicide	
<ul style="list-style-type: none"> • Mental health conditions • Self-harming behaviour • Suicidal ideation • Communicated suicidal intent • Previous suicide attempts • Family and domestic violence • Sexual abuse • Physical abuse • Sexuality and gender identity 	<ul style="list-style-type: none"> • Neglect • Parent living with one or more mental health conditions • Parent experiencing problematic drug and alcohol use • Parent imprisoned • Family member, friend or person known to the young person died by suicide • Alcohol or other drug use • Use of social media
Additional factors associated with suicide by Aboriginal children and young people	
<ul style="list-style-type: none"> • Trauma and intergenerational trauma • Disempowerment 	<ul style="list-style-type: none"> • Removal from parents and community • Racism

Source: Ombudsman Western Australia

8. Theoretical models of suicide by children and young people

Theoretical models of suicide by children and young people commonly identify statistical risk and protective factors, precipitating events, 'triggers' and warning signs. Recent models of suicide theory 'specifically hypothesize that the factors leading to the development of suicidal thinking are distinct from those that govern behavioural enactment, i.e. attempting or dying by suicide'⁸⁹ and therefore may require separate, but related, policy responses.

The research literature notes that, for many children and young people exhibiting suicidal ideation or behaviours, suicide is 'often seen as a solution to intolerable overwhelming feelings rather than an explicit wish to die [and providing] ... a sense of control over feelings of helplessness'.⁹⁰ Further, distress that may otherwise be regarded as 'transient or trivial'⁹¹ by adults can, in fact, present a serious stress and risk to a minority of vulnerable children and young people.

Some of the theoretical models from the research literature that offer explanations of suicide by children and young people include:

⁸⁸ As noted at section 3.2.3, Aboriginal children and young people experience elevated rates of suicide.

⁸⁹ O'Connor R and Kirtley O, 'The integrated motivational-volitional model of suicidal behaviour', *Philosophical transactions of the Royal Society of London, Series B, Biological Sciences*, vol. 373(1754):20170268, 2018, doi:10.1098/rstb.2017.0268.

⁹⁰ Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 17.

⁹¹ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people*, University of Manchester, Manchester, July 2017, p. 21.

- the risk and resilience model of child and adolescent mental health;
- the Interpersonal-Psychosocial Theory of Suicidal Behaviour (**Interpersonal Theory**);
- the Integrated Motivational-Volitional Model of Suicidal Behaviour (**IMV**); and
- the Stress-Vulnerability model.

Considered together, these models reflect observations in the international research literature identifying that the pathway to suicide by children and young people often arises from 'a pattern of cumulative risk [or harm], with traumatic experiences in early life, a build-up of adversity and high risk behaviours in adolescence ... and a 'final straw' event' ... that may not seem severe to others'⁹² such as:

Triggers influencing self-harm and suicidal behavior include:

- Bullying
- Difficulties with parental and peer relationships
- Bereavement
- Earlier abusive experiences
- Difficulties with sexuality
- Problems with ethnicity, culture, religion
- Substance misuse and low self-esteem

Contextual triggers include:

- Adverse family circumstances
- Dysfunctional relationships
- Domestic violence, poverty and parental criminality
- Time in ... [child protection] authority care
- Frequent punishments
- Family transitions⁹³

Each of the models discussed in Chapter 1.2 of Volume 3, is also underpinned by an understanding of self-harm and suicidal behaviours on a spectrum of developmental responses to distress, arising from 'deeper underlying intolerable problems ... [understood] within the context of relationships',⁹⁴ emotions, psychological, social, familial and environmental factors. Under the Interpersonal Theory and IMV, acute stressors or 'triggers' and other 'factors leading to the development of suicidal thinking are distinct from those that govern behavioural enaction, i.e. attempting or dying by suicide.'⁹⁵ Therefore, the emotional, social and physical factors involved in acting on self-harming and suicidal thoughts may require separate, but related, policy responses.

⁹² National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people*, University of Manchester, Manchester, July 2017, p. 21.

⁹³ Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 19.

⁹⁴ Burton M, 'Children and Young People's Mental Health', in Burton M, Pavord E, and Williams B, *An Introduction to Child and Adolescent Mental Health*, Sage Publications, London, 2014, p. 19.

⁹⁵ O'Connor R and Kirtley O, 'The integrated motivational-volitional model of suicidal behaviour', *Philosophical transactions of the Royal Society of London, Series B, Biological Sciences*, vol. 373(1754):20170268, 2018, doi:10.1098/rstb.2017.0268.

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

Suicide prevention strategies provide a systematic way for governments to respond to suicide through a range of coordinated prevention activities. The World Health Organization identifies that successful suicide prevention strategies:

- make prevention a multisectoral priority that involves not only the health sector but also education, employment, social welfare, the judiciary and others'; ...
- [are] tailored to ...[the] cultural and social context; ...
- [establish] best practices and evidence-based interventions; ...
- [allocate resources] for achieving both short-to-medium and long-term objectives ... [through] effective planning; ... [and]
- [are] regularly evaluated, with evaluation findings feeding into future planning.⁹⁶

9.1 The Mrazek and Haggerty model

In the 2014 Investigation, the Office identified that the Western Australian Suicide Prevention Strategy 2009 – 2013: Everybody's Business (**the former State Strategy**) was informed by the Mrazek and Haggerty *Spectrum of Interventions for Mental Health Problems and Mental Disorders* (**the Mrazek and Haggerty model**).⁹⁷

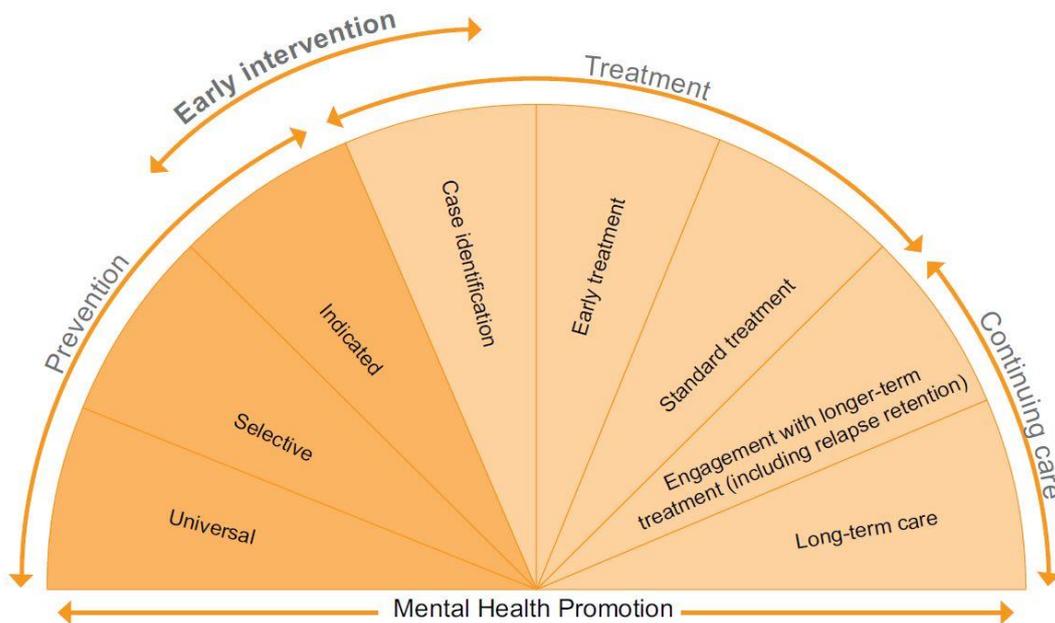
The Mrazek and Haggerty model divides interventions for mental health issues into three categories – Prevention, Treatment and Continuing Care – and further into eight domains within these categories. Similarly, the former State Strategy identified that it was based upon the 'Prevention' category of the Mrazek and Haggerty model, namely activities that 'can be targeted universally at the generally population ... focus on selective at-risk groups or ... be directed to those at risk as required.'⁹⁸

⁹⁶ World Health Organization, *Preventing suicide: a global imperative*, WHO, Luxembourg, 2014, p. 8.

⁹⁷ Mrazek P and Haggerty R (eds), *Reducing risks for mental disorders: frontiers for preventative intervention research*, National Academies Press, Washington, 1994.

⁹⁸ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009–2013 Everybody's Business*, Department of Health, Perth, 2009, p. 30.

Figure 9: Spectrum of interventions for mental health problems and mental disorders



Source: Western Australian Suicide Prevention Strategy 2009 – 2013

9.2 Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project

ATSISPEP was established to gather the evidence about what works in preventing suicide by Aboriginal and Torres Strait Islander people and developed a:

... set of success factors ... [for] community-led, Indigenous suicide prevention programs' centred upon responses developed and implemented 'through Indigenous leadership ... in partnership with Indigenous communities ... [and with] the empowerment of communities.⁹⁹

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

⁹⁹ Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, pp. 1-2.

Figure 10: ATSIPEP Success Factors

UNIVERSAL/ INDIGENOUS COMMUNITY – WIDE	Primordial prevention	<ul style="list-style-type: none"> Addressing community challenges, poverty, social determinants of health Cultural elements – building identity, SEWB, healing Alcohol/drug use reduction
	Primary prevention	<ul style="list-style-type: none"> Gatekeeper training – Indigenous-specific Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy Reducing access to lethal means of suicide Training of frontline staff/GPs in detecting depression and suicide risk E-health services/internet/crisis call lines and chat services Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	School age	<ul style="list-style-type: none"> School-based peer support and mental health literacy programs Culture being taught in schools
	Young people	<ul style="list-style-type: none"> Peer-to-peer mentoring, and education and leadership on suicide prevention Programs to engage/divert including sport Connecting to culture/country/Elders Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	Clinical elements	<ul style="list-style-type: none"> Access to counsellors/mental health support 24/7 availability Awareness of critical risk periods and responsiveness at those times Crisis response teams after a suicide/postvention Continuing care/assertive outreach post ED after a suicide attempt Clear referral pathways Time protocols High quality and culturally appropriate treatments Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	Community leadership/ cultural framework	<ul style="list-style-type: none"> Community empowerment, development, ownership – community-specific responses Involvement of Elders Cultural framework
	Provider	<ul style="list-style-type: none"> Partnerships with community organisations and ACCHS [Aboriginal Community Controlled Health Services] Employment of community members/peer workforce Indicators for evaluation Cross-agency collaboration Data collections Dissemination of learnings

Source: ATSIPEP¹⁰⁰

¹⁰⁰Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, p. 3.

9.3 The National Suicide Prevention Strategy

The National Suicide Prevention Strategy (**National Strategy**), as outlined in the 2014 Investigation, remains 'the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention.'¹⁰¹

A key component of the National Strategy is the Living Is For Everyone (**LIFE**) Framework which 'provides a summary of the range of types of suicide prevention activities and interventions that are essential for a whole of community response to reducing the rate of suicide in Australia.'¹⁰² Consistent with the Mrazek and Haggerty model, the LIFE Framework includes interventions 'across eight overlapping domains of care and support', as follows:

1. *Universal interventions* aim to engage the whole of a population ... to reduce access to means of suicide, reduce inappropriate media coverage of suicide, and to create stronger and more supportive families, schools and communities.
2. *Selective interventions* entail working with groups and communities who are identified as at risk to build resilience, strength and capacity and an environment that promotes self-help and support. ...
3. *Indicated interventions* target people who are showing signs of suicide risk or present symptoms of an illness known to heighten the risk of suicide ...
4. *Symptom identification* – knowing and being alert to signs of high or imminent risk, adverse circumstances and potential tipping points by providing support and care when vulnerability and exposure to risk are high.
5. *Finding and accessing early care and support* when treatment and specialised care is needed ...
6. *Standard treatment* when specialised care is needed ...
7. *Longer-term treatment and support* to assist in preparing for a positive future ...
8. *Ongoing care and support* involving professionals, workplaces, community organisations, friends and family to support people to adapt, cope, and build strength and resilience within an environment of self-help.¹⁰³

The LIFE Framework also includes six Action Areas:

- Action Area 1 – Improving the evidence base and understanding of suicide prevention;¹⁰⁴
- Action Area 2 – Building individual resilience and the capacity for self-help;¹⁰⁵

¹⁰¹ Department of Health, *National suicide prevention strategy*, Australian Government, Canberra, May 2012.

¹⁰² Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹⁰³ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹⁰⁴ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹⁰⁵ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

- Action Area 3 – Improving community strength, resilience and capacity in suicide prevention;¹⁰⁶
- Action Area 4 – Taking a coordinated approach to suicide prevention;¹⁰⁷
- Action Area 5 – Providing targeted suicide prevention activities;¹⁰⁸ and
- Action Area 6 – Implementing standards and quality in suicide prevention.¹⁰⁹

9.4 The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (**ATSI Strategy**) identifies six 'Action Areas' that align with the 'Action Areas' in the National Strategy but are in a different order 'to reflect the logic of engagement of Aboriginal and Torres Strait Islander communities and the priority that needs to be given to supporting community leadership and community action in suicide prevention.'¹¹⁰

The ATSI Strategy identifies that communities that have strong cultural continuity have lower rates of young people that die by suicide, making cultural continuity a critical factor for Aboriginal and Torres Strait Islander suicide prevention.¹¹¹

The ATSI Strategy also identifies the need for culturally competent services that provide culturally safe management and treatment based on Aboriginal and Torres Strait Islander peoples' understanding of culture, family and connection to the land. Culturally competent suicide prevention services are those that are developed in partnership with the local community and Aboriginal and Torres Strait Islander Community Controlled Health Services, and aim to:

- Provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their lives and to mitigate the reverberations from suicide in the client's community;
- Be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety;
- Establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations; and
- Be based on Aboriginal and Torres Strait Islander peoples' definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.¹¹²

¹⁰⁶ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹⁰⁷ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹⁰⁸ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹⁰⁹ Department of Health and Aging, *Living Is For Everyone (LIFE) Framework*, Australian Government, Canberra, 2008, p. 20.

¹¹⁰ Department of Health and Aging, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Australian Government, Canberra, 2013, pp. 26-45.

¹¹¹ National Mental Health Commission, *A Contributing Life*, the 2013 National Report Card on Mental Health and Suicide Prevention, NMHC, Australian Government, Sydney, 2013, p. 89.

¹¹² National Mental Health Commission, *A Contributing Life*, the 2013 National Report Card on Mental Health and Suicide Prevention, NMHC, Australian Government, Sydney, 2013, pp. 89-90.

9.5 Australian Government Youth Mental Health and Suicide Prevention Plan

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

\$503 million [to a new] Youth Mental Health and Suicide Prevention Plan ... [including] a major expansion of the headspace network and a significant boost to Indigenous suicide prevention and early childhood and parenting support.¹¹³

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

- Report on the effectiveness of the design, coordination and delivery of suicide prevention activities in Australia, with a focus on people in crisis or increased risk, including young people and our first nations people;
- Develop options for a whole-of-government coordination and delivery of suicide prevention activities to address complex issues contributing to Australia's suicide rate, with a focus on community-led and person-centred solutions;
- Work across government and departments to embed suicide prevention policy and culture across all relevant policy areas to ensure pathways to support are cleared, and people who are at an increased risk of suicide are able to access support; and
- Draw upon all current relevant work government and the sector is undertaking to address suicide, including the Fifth National Mental Health and Suicide Prevention Plan and Implementation Strategy, and the findings of the Productivity Commission and Royal Commission into Victoria's Mental Health System inquiries.¹¹⁴

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

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

- was based on the National Strategy;
- provided 'the foundational framework for the State government to coordinate and invest in suicide prevention strategies at all levels in the community';¹¹⁵ and
- included 'a particular emphasis on young people, young men, Aboriginal people and people who live in rural and regional Western Australia.'¹¹⁶

The Auditor General's 2014 *Report on The Implementation and Initial Outcomes of the Suicide Prevention Strategy* identified that the former State Strategy had 'succeeded in engaging communities in planning and participating in suicide prevention activities that they

¹¹³ The Hon Scott Morrison MP, Prime Minister of Australia, *Media Release: Making suicide prevention: a national priority*, 8 July 2019, viewed, 28 October 2019, <<https://www.pm.gov.au/media/making-suicide-prevention-national-priority>>.

¹¹⁴ National Mental Health Commission, *Commission CEO appointed the National Suicide Prevention Adviser to the Prime Minister*, 8 July 2019, viewed 28 October 2019, <<https://www.mentalhealthcommission.gov.au/media-centre/news/commission-ceo-appointed-the-national-suicide-prevention-adviser-to-the-prime-minister.aspx>>.

¹¹⁵ Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Government of Western Australia, Perth, 2009, p. 8.

¹¹⁶ Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Government of Western Australia, Perth, 2009, p. 4.

felt would work for them' but also experienced 'delays ... cost[ing] time, effort and money' arising from issues relating to 'procurement ... planning ... and governance arrangements'.¹¹⁷

The current State Strategy, *Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020)* was released in 2015, and 'aims to halve the number of suicides in ten years'.¹¹⁸ *Suicide Prevention 2020* recognises that a person's 'physical, cultural and social circumstances can result in greater disadvantage and risk of suicide' and outlines seven 'priority populations for suicide prevention actions across Western Australia' as follows:¹¹⁹

- People dealing with trauma in the workplace, including first responders and former defence force personnel;
- People bereaved by suicide, particularly children;
- Aboriginal people;
- People from culturally and linguistically diverse backgrounds;
- Lesbian, gay, bisexual, transgender, and intersex people;
- People living in rural and remote areas;
- People in the justice system;
- Those who have attempted suicide; and
- People who use alcohol or other drugs.¹²⁰

In its 2016 report, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas (Learnings from the message stick)*, the Education and Health Standing Committee observed that 'an Implementation Plan, Aboriginal Implementation Plan and Youth Engagement Strategy have been developed [to guide actions under *Suicide Prevention 2020*]' . However, to date, these documents have not been released publicly.

9.7 State Suicide Prevention Action Plan 2021-2025

As part of the 2019-20 State Budget, the State Government allocated an additional \$8.1 million to extend *Suicide Prevention 2020* for a further 18 month period beyond 30 June 2019.¹²¹ On 3 July 2019, the Mental Health Commission announced that it was 'developing a new suicide prevention strategy, the *Suicide Prevention Action Plan 2021-2025*' and a draft was released for public comment from 9 October 2019 to 22 October 2019.

9.8 Comparison of Commonwealth and State government suicide prevention strategies

A review of Australian suicide prevention strategies by the National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention (**the Black Dog Institute**), found that the majority of suicide prevention strategies at both the Commonwealth

¹¹⁷ Auditor General, *The Implementation and Initial Outcomes of the Suicide Prevention Strategy*, Perth 2014, p. 4.

¹¹⁸ Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015.

¹¹⁹ Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, p. 20.

¹²⁰ Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Perth, 2015, pp. 20-22.

¹²¹ Government of Western Australia, *WA State Budget 2019-20: Putting Patients First*, 2019, viewed 28 October 2019, <<https://www.ourstatebudget.wa.gov.au/2019-20/fact-sheets/health.pdf>>; Aboriginal Health Council of Western Australia, Mooritj Koort and Western Australian Association for Mental Health, *Media release: State Budget does not properly address Aboriginal suicide prevention*, 10 May 2019, viewed 28 October 2019, <https://waamh.org.au/assets/documents/media-releases/media-release-joint-statement-aboriginal-suicide-prevention-budget-may-2019_final.pdf>.

and State/Territory levels aimed to 'engage multiple stakeholders and to coordinate between federal and jurisdictional levels, to build capacity within the health system and the wider community, to promote knowledge of effective interventions, and to develop implementation plans and evaluate the strategy.'¹²²

The Black Dog Institute also identified that evaluation of suicide prevention strategies was 'brief and imprecise' and that most were missing:

- 'the aim to address the social determinants of suicide, e.g. unemployment, inequality, unemployment and violence';
- 'a specific focus on addressing alcohol abuse (and/or dual diagnosis)'; and
- 'clear recognition or plan to develop multi-compartmental strategies.'¹²³

Despite these issues, Australian mental health policy has been recognised as 'world leading'.¹²⁴ However, the research literature¹²⁴ notes that 'the implementation of suicide prevention policies has been less comprehensive ...[with] evidence ... mounting that the best suicide prevention approach is likely to be gained from a multi-level, multifactorial systems based approach.'¹²⁵

Everymind (formerly known as the Hunter Institute of Mental Health), has noted that the Mrazek and Haggerty model's 'spectrum concept has been useful for policy makers and service providers in considering actions or interventions that might be most effective for people in different circumstances.' However, they also note that the Mrazek and Haggerty model 'is not used or understood by sectors outside of health' and that in practice it 'has not clearly articulated the full range of prevention activities (other than primary prevention), nor has it emphasised the importance of recovery.'¹²⁶ These concerns are also noted in the Council of Australian Governments (**COAG**) Health Council's *Fifth National Mental Health and Suicide Prevention Plan*, which states that:

The current approach to suicide prevention has been criticised as being fragmented, with unclear roles and responsibilities across governments. This has led to duplication and gaps in services for consumers. Where there are competing or overlapping services, there is a lack of clarity about which services are most effective or efficient.¹²⁷

¹²² Christensen H et al, *Literature Review for the Development of the Report Card: What works in suicide prevention*; National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention Black Dog Institute, Randwick, 2013, viewed 10 September 2018, <<http://www.mentalhealthcommission.gov.au/media/100033/What%20works%20in%20suicide%20prevention.pdf>>, pp. 23-24.

¹²³ Christensen H et al, *Literature Review for the Development of the Report Card: What works in suicide prevention*; National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention Black Dog Institute, Randwick, 2013, viewed 10 September 2018, <<http://www.mentalhealthcommission.gov.au/media/100033/What%20works%20in%20suicide%20prevention.pdf>>, pp. 23-24.

¹²⁴ National Mental Health Commission, *Contributing Lives, Thriving Communities: National Review of Mental Health Programmes and Services: Volume 4 – Paper 2: Mental health need and Australia's response*, NMHC, Sydney, 2014, viewed 10 September 2018, <<http://www.mentalhealthcommission.gov.au/media/119956/Vol%204%20Paper%20-%20Review%20of%20Mental%20Health%20Programmes%20and%20Services.pdf>>, p. 3.

¹²⁵ Christensen H, 'Suicide prevention in Australia: Where to from here', *InPsych*, vol. 38, no. 1, 2016, viewed 10 September 2018, <<https://www.psychology.org.au/inpsych/2016/feb/Christensen>>.

¹²⁶ Everymind, *Prevention First Framework: A Prevention & Promotion Framework for Mental Health*, Version 2, Newcastle, Australia, 2017, p. 19.

¹²⁷ Council of Australian Governments Health Council, *The Fifth National Mental Health and Suicide Prevention Plan*, COAG Health Council, August 2017, p. 24.

9.9 The systems based approach to suicide prevention

The Black Dog Institute¹²⁸ and other stakeholders including the Chief Psychiatrist of Western Australia¹²⁹ and the National Centre of Excellence in Youth Mental Health (**Orygen**) have endorsed a shift to a multi-sectorial, systems based approach to suicide prevention delivered in a joined up, integrated manner by relevant stakeholders in each community.

The systems-based suicide prevention approach developed by the Black Dog Institute involves nine population based and individual level strategies, namely:

- aftercare and crisis care following a suicide attempt;
- psychosocial and pharmacotherapy treatments;
- GP capacity building and support;
- frontline staff training;
- gatekeeper training;
- school programs;
- community mental health literacy campaigns;
- media reporting guidelines; and
- means restriction data collection, analysis and evidence-based practice.¹³⁰

The Black Dog Institute's systems-based approach is used by the Australian Government's Primary Health Network led National Suicide Prevention Trial, which includes three Western Australian trial sites in Perth South (youth); the Mid-West (men 25-54 years); and the Kimberley (Aboriginal people).¹³¹

Orygen have also noted that a systems response to self-harm and suicide prevention for children and young people 'urgently' requires 'appropriate and continuing care' after leaving hospital, 'high quality treatment (CBT [cognitive behavioural therapy] and DBT [dialectical behavioural therapy]' in addition to:

- 'Postvention supports';
- 'Provision of specialist mental health services';

¹²⁸ Black Dog Institute, *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring*, Australian Government, National Health and Medical Research Council, Black Dog Institute, 2016, viewed 9 May 2019, <<https://www.blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0>>.

¹²⁹ Chief Psychiatrist of Western Australia, 'An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring', 31 August 2017, viewed 9 May 2019, <<https://www.chiefpsychiatrist.wa.gov.au/an-evidence-based-systems-approach-to-suicide-prevention-guidance-on-planning-commissioning-and-monitoring/>>.

¹³⁰ Black Dog Institute, *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring*, Australian Government, National Health and Medical Research Council, Black Dog Institute, 2016, p. 2, viewed 9 May 2019, <<https://www.blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0>>.

¹³¹ Life in Mind, *Programs & resources, Regional approaches to suicide prevention – National Suicide Prevention Trial*, 2018, viewed 26 September 2018, <<https://www.lifeinmindaustralia.com.au/programs-resources/regional-approaches/phn>>.

- 'Strong emphasis on the role of technology'; and
- 'Co-design with young people'.¹³²

These elements are featured in the only specific Australian suicide prevention strategy for children and young people, the *Youth Suicide Prevention Plan for Tasmania 2016-2020*. The *Youth Suicide Prevention Plan for Tasmania* prioritises 'an all of government, all-of-service system and whole-of-community approach to the prevention of suicide' including five action areas for children and young people aged 12-25:

1. Start early by focusing on the resilience, mental health and wellbeing of children, parents and families.
2. Empower young people, families and wider community networks to talk about suicide and respond to young people at risk of suicide.
3. Build the capacity of schools and other educational settings to support young people who may be at risk of suicide or impacted by suicide.
4. Develop the capacity of the service system to support young people experiencing suicidal thoughts and behaviours.
5. Respond effectively to the suicide of a young person to minimize the impact on other young people in Tasmania.¹³³

10. Preventing and reducing suicide by children and young people

10.1 Improving the timeliness and publication of data on suicide, suicide attempts and self-harm by children and young people

The *Youth Suicide Prevention Plan for Tasmania* also places an emphasis on greatly enhanced data collection and evaluation, which the World Health Organization has also recognised as 'important' and 'integral' components for planning, implementing, managing and capturing the knowledge produced from a suicide prevention strategy.¹³⁴

ATSISPEP's *Real Time Suicide Data: A Discussion Paper* poignantly highlights that 'work to improve the speed of availability of data, and its quality ... [cannot be] underestimate[d] ... if timely knowledge of a suicide saves just one further life, its value cannot be denied.'¹³⁵

The Office notes the pleasing progress that has been made in recent years by the Department of Health in capturing self-harm hospital attendances and admissions data in relation to children and young people, particularly in regional areas. However, the Office also acknowledges the gaps that exist in our population level self-harm data. Continuous improvement of self-harm data collection and monitoring systems in hospital 'will lead to better care for people who have self-harmed, while linking to research databases would then enable the impact of policy, program and clinical interventions to be better tracked, compared and reported over time.'¹³⁶

¹³² J Robinson, E Bailey, V Browne et al, *Looking the Other Way: Raising the Bar for Youth Suicide Prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 45.

¹³³ Department of Health and Human Services, Tasmanian Government, *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, March 2016, p. 7.

¹³⁴ World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, pp. 60-61.

¹³⁵ Aboriginal and Torres Strait Islander Suicide Evaluation Project, *Real Time Suicide Data: A Discussion Paper*, viewed 21 March 2019, <https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf>, p. 8.

¹³⁶ Robinson J et al, *Looking the Other Way: Young people and self-harm*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 14.

Accordingly, the Ombudsman has made the following recommendation:

Recommendation 4: That the Mental Health Commission and the Department of Health working collaboratively to:

- investigate the feasibility of developing a linked sentinel data collection system recording the prevalence of, and characteristics associated with, self-harm by children and young people; and
- consider selecting a number of hospitals in Western Australia representative of Western Australia's population demographics, building on both the Newcastle model and United Kingdom multicentre study cited in Orygen's *Looking the other way: young people and self-harm* report.

10.2 Improving data collection on suicide, self-harm and mental illness in LGBTQI+ children and young people

As identified in Chapters 3.5.8 and 5.1 of Volume 3, LGBTQI+ communities across the world are a vulnerable group with higher rates of suicide.¹³⁷

A 2015 comparative study conducted by the Australian Institute for Suicide Research and Prevention found 'a great deal of emotion, conflict, and distress in the lives of those LGBT individuals that died by suicide ... characterised principally by non-acceptance (by family but also by self)'.¹³⁸ The Telethon Kids Institute's 2017 report *Trans Pathways: the mental health experiences and care pathways of trans young people* also identified that rates 'of self-harm and suicidality were extremely high' in the trans young people aged 14 to 25 years surveyed with '79.7 per cent of participants ever self-harming and 48.1 per cent ever attempting suicide'.¹³⁹

However, a significant gap in the evidence base exists in relation to the data for suicide, suicide attempts and self-harm children and young people who identify as same-sex attracted or gender diverse in Western Australia.

In some jurisdictions, government guidelines provide guidance as to the collection of sex, gender, and sexual orientation data, such as the *Australian Government Guidelines on the Recognition of Sex and Gender* (2013). These Guidelines relevantly recognise that:

The preferred Australian Government approach is to collect and use gender information. Information regarding sex would ordinarily not be required and should only be collected where there is a legitimate need for that information and it is consistent with Australian Privacy Principle 3 ...

Departments and agencies should ensure when they collect sex and/or gender information they use the correct terminology for the information they are seeking.¹⁴⁰

¹³⁷ World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 37.

¹³⁸ Skerrett DM, Kólves K, and De Leo D, Suicidal behaviours in LGBT populations: Final Report to the beyondblue, Australian Institute for Suicide Research and Prevention, 2015, pp. 4 and 6.

¹³⁹ Strauss P et al, 'Summary of results', *Trans Pathways: the mental health experiences and care pathways of trans young people*, Telethon Kids Institute, Perth, Australia, 2017, p. 34.

¹⁴⁰ Australian Government, *Australian Government Guidelines on the Recognition of Sex and Gender*, November 2015, viewed 26 October 2019, <<https://www.ag.gov.au/Publications/Documents/AustralianGovernmentGuidelinesontheRecognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.pdf>>, p. 4.

Through the work undertaken as part of the 2020 Investigation, the Office identified that State government departments and authorities, including the Department of Communities and Department of Health, record different sets of data relating to sex and gender, as summarised in Table 7:

Table 7: Summary of data recorded relating to sex and gender, by State government department

	Department of Health	Department of Communities
Does the department or authority record sex or gender?	Biological sex data is recorded in the Emergency Department Data Collection. 'Gender' is recorded in the TOPAS, HCARE and webPAS systems however, is defined as biological sex. Gender identity data is not captured.	Gender
Is sex or gender data captured in a non-binary format?	Sex data is captured in a non-binary format, as: <ul style="list-style-type: none"> • male, female or indeterminate in TOPAS, HCARE and webPAS;¹⁴¹ and • male, female, 'intersex or indeterminate, or not stated/inadequately described' in the Emergency Department Data Collection.¹⁴² 	No: Binary
Are there any relevant legislative or policy considerations relating to the recording of data on sex and gender?	Binding Information Management Policy Framework issued by the Director General under section 26 of the <i>Health Services Act 2016</i> ¹⁴³	None publicly available

Source: Ombudsman Western Australia

The *Victorian Family Violence Data Collection Framework* contains guidelines for collecting data relating to family violence experienced by LGBTIQ+ communities and states that 'organisational change and staff training' are vital to inclusive service delivery and data collection practices, including 'recognising when it may not be appropriate to ask, and in how to sensitively and respectfully collect data.' It also observes that agencies should take particular care to avoid the harms and misunderstanding that can arise from misgendering and 'making assumptions about a person's gender identity, sex, sexual orientation or intersex variation.'¹⁴⁴

Further, the *Victorian Family Violence Data Collection Framework* highlights the importance respecting the wishes of LGBTIQ+ people concerning confidentiality and any circumstances in which they may decline to disclose information, given the potentially 'significant impact on [their] ... safety, health and wellbeing and ... social connectedness.'¹⁴⁵ Under the guidelines provided in the Framework, sexual orientation data should only be collected in circumstances where:

¹⁴¹ Department of Health, *Hospital Morbidity Data System: HMDS Reference Manual*, Government of Western Australia, Perth, 2015, pp. 159-160.

¹⁴² Department of Health, *Emergency Department Data Collection Data Dictionary*, Government of Western Australia, Perth, 2007, pp. 104-105.

¹⁴³ Department of Health, *Information Management, Version 10*, 18 October 2018.

¹⁴⁴ Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

¹⁴⁵ Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

- agencies are 'aware of and understand the needs of diverse LGBTI communities so that they may collect information appropriately, and provide an appropriate response';¹⁴⁶
- people are willing to disclose;¹⁴⁷
- the information can be collected and stored sensitivity, bearing in mind privacy implications and relevant legislative requirements;¹⁴⁸ and
- there is a clear link to 'a direct service response or referral to an appropriate service'.¹⁴⁹

Accordingly, there is an opportunity to enhance our understanding of suicide and self-harm by LGBTIQ+ children and young people in Western Australia by improving the consistency of the recording of relevant gender and sexual identity data by the Department of Health and Department of Communities.

For these reasons, the Ombudsman has made the following recommendation:

Recommendation 5:

- That the Department of Health and Department of Communities should collect gender data in a non-binary form when this is provided with a child or young person's consent and would not offend, 'out', or otherwise inappropriately disclose a child or young person's gender identity.
- That the Department of Health and Department of Communities should record information about a child or young person's sexuality where this is provided with the child or young person's consent, is relevant to their suicidal or self-harming behaviour, and does not offend, 'out', or otherwise inappropriately disclose a child or young person's sexual identity.

10.3 Evidence-based interventions

10.3.1. Early years intervention and trauma-informed prevention

The research literature previously discussed identifies the importance of whole-of-government early intervention strategies in improving the wellbeing of children and young people and reducing the risk of suicidal and self-harming behaviours.

The World Health Organization notes that upstream prevention strategies 'addressing risk and protective factors early in the life course' may 'shift the odds in favour of more adaptive outcomes over time ... [and] simultaneously impact a wide range of health and societal outcomes such as suicide, substance abuse, violence and crime'.¹⁵⁰ Upstream suicide prevention strategies for children and young people include:

- Early childhood home visits to provide education by trained staff (e.g. nurses) to low-income expectant/new mothers.

¹⁴⁶ Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 54.

¹⁴⁷ Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 54.

¹⁴⁸ Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 56.

¹⁴⁹ Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

¹⁵⁰ World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, pp. 44-45

- Mentoring programmes to enhance connectedness between vulnerable young people and supportive, stable and nurturing adults.
- Community-wide prevention systems to empower entire communities to address adolescent health and behaviour problems through a collaborative process of engagement.
- School-based violence prevention and skill-building programmes to engage teachers/staff, students and parents in fostering social responsibility and social-emotional skills-building (e.g. coping, problem-solving skills, help-seeking).¹⁵¹

The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) Faculty of Child and Adolescent Psychiatrists is also of the view that developmentally informed 'prevention, early intervention and mental health promotion for infants, children and adolescents' are 'imperative to the prevention of mental disorder [including suicide and self-harm] later in life'. It states:

Mental health is an issue for the entire community and requires a whole of community response. Responsibility should sit across portfolios and involve family and community services, educational institutions, recreation sectors, as well as consumer and carer groups. ...

Early experiences determine whether a child's developing brain architecture provides a strong or weak foundation for all future learning, behaviour, and health. Mental health problems during early years can have enduring consequences if left unresolved not only by placing individuals at increased risk of difficulties in adult life, but also by placing increased pressure on limited community service resources. Suffering and negative outcomes can also cause intergenerational cycles which become larger problems to address. ...

It is known that preventative programs in childhood are effective when they target multiple risk factors concurrently ... The priority now is to ensure that such programs are properly implemented and evaluated to achieve optimum outcomes for childhood mental health.¹⁵²

'Early intervention' refers to interventions taking place during the first 1,000 days of a child's development (from conception to their third birthday), when 80 per cent of the brain is formed. Early intervention is also identified by the World Health Organization and the United Nations International Children's Emergency Fund (UNICEF) as a cost-effective investment in all children's right to survive and thrive and a society's future prosperity:

Investing in early childhood development is good for everyone – governments, businesses, communities, parents and caregivers, and most of all, babies and young children. ... For every \$1 spent on early childhood development interventions, the return on investment can be as high as \$13.

Meanwhile, the cost of inaction is high. Children who do not have the benefit of nurturing care in their earliest years are more likely to encounter learning

¹⁵¹ World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, pp. 44-45

¹⁵² The Royal Australian and New Zealand College of Psychiatrists, *Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning strategies for Australia and New Zealand*, Faculty of Child and Adolescent Psychiatry, RANZCP, Melbourne, 2010, viewed 26 October 2019, <<https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx>>, pp. 7, 10.

difficulties ... in turn reducing their future earnings and impacting the wellbeing and prosperity of their families and societies.¹⁵³

More particularly, the RANZCP has noted that early intervention programs focused on the first 1,000 days focused on children 'who have experienced significant trauma and adversity' and 'assisting new parents, families and schools' reduce the likelihood of 'challenges ... such as mental health issues, obesity, heart disease, criminality, and poor literacy and numeracy, [that] can be traced back to pathways that originated in early childhood.'¹⁵⁴

10.3.2. Suicide prevention and promoting healthy development during middle childhood and adolescence

The research literature also observes that mental health promotion and suicide prevention interventions are critical beyond the early years, with 'the complex nature of suicide related behaviours and self-harm require[ing] the inclusion of interventions that have a broader focus than self-harm alone.'¹⁵⁵ Suicide prevention activities for children and young people must also effectively address the recognised barriers preventing those at risk of suicidal and self-harming behaviours from receiving the help they need. Orygen has identified that these barriers include stigma, low mental health literacy, a lack of access to appropriate services, negative experiences with 'front-line' health professionals and insufficient care and follow-up after self-harm.¹⁵⁶

Universal interventions: awareness campaigns, gatekeeper training, improving referral pathways to specialist mental health services and culturally responsive community-led responses

The evidence base for suicide and self-harm prevention interventions for children and young people is limited, particularly in Australia where access to timely population data is difficult and contracting of health and social services is often output based, rather than outcomes based. However, a recent Australian meta-analysis by Orygen found moderate benefits from universal awareness campaigns and gatekeeper training programs with identifiable pathways to referrals and treatment. Orygen also identified that universal school based programs 'based on behavioural change were found to be effective [and] ... associated with significant reductions across a variety of suicide-related behaviours'¹⁵⁷ Culturally, community-led suicide prevention responses were noted to have 'demonstrated efficacy ... [in] providing community members with coping strategies within a culturally responsive and supportive framework' and 'significant[ly] decreas[ing] ... suicide rates.'¹⁵⁸

¹⁵³ World Health Organization, United Nations Children's Fund, World Bank Group, Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential, WHO, Geneva, 2018, p. 1.

¹⁵⁴ 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.

¹⁵⁵ Robinson J et al, *Looking the Other Way: Young people and self-harm*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 43.

¹⁵⁶ Robinson J et al, *Looking the Other Way: Young people and self-harm*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

¹⁵⁷ Robinson J et al, *Looking the Other Way: Young people and self-harm*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 43.

¹⁵⁸ Robinson J et al, *Looking the Other Way: Young people and self-harm*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 43.

Selective interventions for at-risk groups: strengthen community and environmental supports; postvention supports for those bereaved by suicide; enhanced prevention in places or communities with high rates of suicide, self-harm and child abuse or neglect

The efficacy of school-based postvention programs for children and young people bereaved by one or more students who died by suicide is also supported by evidence.¹⁵⁹ However, the research literature acknowledges that, 'despite a great deal of evidence ... clearly demonstrating that [exposure to] parental suicidal behaviour' may be a significant risk factor' for suicide by children and young people, postvention studies are 'lacking' for this cohort.¹⁶⁰ There is some limited evidence suggesting that interventions promoting 'adaptive parent-child relationships and behaviours can protect against negative developmental trajectories [including suicide]'¹⁶¹ amongst this group of children and young people. The research literature notes that 'promising results' from interventions for children and young people with parents experiencing mental ill-health suggests that the offspring of parents who attempt suicide may also benefit from interventions 'targeted at improving attachment and familial management, as well as reducing the environmental exposure of risk factors [such as neglect and sexual abuse]'.¹⁶²

Indicated clinical interventions for at risk individuals: assertive follow up and transition to community care after hospital treatment for self-harm or suicide attempts

The research literature notes the importance of services working flexibly in providing support to individual children and young people at risk of suicide, such as 'keep[ing] doors to treatment open'¹⁶³ ensuring '24/7 availability' and 'assertive outreach'¹⁶⁴ to connect and engage with children, young people, families and communities.

In particular, the research literature highlights the importance of targeting prevention efforts at children and young people upon discharge from hospital following an attempted suicide, as a time of critical risk where out of hours and rapid responses may be required.¹⁶⁵ The research literature also notes that 'hospitalized adolescents should get a "front loading" of treatment, since the risk of recurrence [of attempted suicide] is highest right after discharge'.¹⁶⁶ There is also evidence supporting the efficacy of Emergency Department Counselling on Access to Lethal Means for parents of children and young people who have

¹⁵⁹ J Robinson et al, *Raising the bar for youth suicide prevention: Appendix 1 – Evidence review youth suicide prevention (2016)*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

¹⁶⁰ Lunde I et al, 'Systematic Literature Review of Attempted Suicide and Offspring', *International Journal of Environmental Research and Public Health*, vol. 15, no. 5, May 2018, p. 937, doi: 10.3390/ijerph15050937.

¹⁶¹ Lunde I et al, 'Systematic Literature Review of Attempted Suicide and Offspring', *International Journal of Environmental Research and Public Health*, vol. 15, no. 5, May 2018, p. 937, doi: 10.3390/ijerph15050937.

¹⁶² Lunde I et al, 'Systematic Literature Review of Attempted Suicide and Offspring', *International Journal of Environmental Research and Public Health*, vol. 15, no. 5, May 2018, p. 937, doi: 10.3390/ijerph15050937.

¹⁶³ American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, *Children and Trauma: Update for Mental Health Professionals*, American Psychological Association, Washington DC, 2008, p. 5.

¹⁶⁴ Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, p. 3

¹⁶⁵ Dudgeon P et al, *Solutions That Work: What the Evidence of our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report*, School of Indigenous Studies, UWA, November 2016, p. 3.

¹⁶⁶ Brent, David A et al. "Protecting adolescents from self-harm: a critical review of intervention studies." *Journal of the American Academy of Child and Adolescent Psychiatry* vol. 52,12 (2013): 1260-71. doi:10.1016/j.jaac.2013.09.009.

attempted suicide, including the provision of safe storage boxes for medications and firearms, in reducing access to lethal means.¹⁶⁷

The research literature further identifies that targeted interventions with the greatest success in adolescents have been broader psychosocial treatments relating to 'the augmentation of familiar and other sources of support, provision of a sufficient dose of treatment, ... attention to sobriety and motivation ... family processes ... and internal representations of attachment.'¹⁶⁸ Treatments aimed at addressing issues relating to 'sleep and positive affect'¹⁶⁹ have also shown promise.

Other evidence indicates the effectiveness of telephone counselling, cognitive behavioural therapy, family interventions, dialectical behavioural therapy, multi-modal pharmacological intervention for outpatients and other children and young people in the community identified as being at risk of suicide.¹⁷⁰ Online cognitive behavioural therapy delivered in secondary schools has also shown effectiveness in significantly decreasing levels of suicidal ideation and promoting help-seeking behaviour in adolescents.¹⁷¹

Some interventions, such as Dialectical Behaviour Therapy for Adolescents, Mentalisation-Based Therapy for Adolescents and Good Clinical Care also 'show promise in reducing the frequency of self-harm'.¹⁷²

In hospital settings, there is evidence supporting the use of problem-solving, multi-modal and psychological interventions (mode deactivation therapy and dialectical behavioural therapy) in both emergency departments and inpatient facilities.¹⁷³

10.3.3. The role of State government departments and authorities

In the 2014 Investigation, the Office noted that the patterns identified during the course of that investigation may have implications for Western Australia, in particular that:

- different suicide prevention activities may be relevant to each of the four groups of children and young people who died by suicide;
- preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child abuse or neglect and mental health issues;
- State government departments and authorities have an important role to play in preventing suicide by young people, including the Department of Health, the Department of Communities and the Department of Education;

¹⁶⁷ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, Centres for Disease Control and Prevention, Atlanta Georgia, 2017, p. 25.

¹⁶⁸ Brent, David A et al. "Protecting adolescents from self-harm: a critical review of intervention studies." *Journal of the American Academy of Child and Adolescent Psychiatry* vol. 52,12 (2013): 1260-71. doi:10.1016/j.jaac.2013.09.009.

¹⁶⁹ Brent, David A et al. "Protecting adolescents from self-harm: a critical review of intervention studies." *Journal of the American Academy of Child and Adolescent Psychiatry* vol. 52,12 (2013): 1260-71. doi:10.1016/j.jaac.2013.09.009.

¹⁷⁰ J Robinson et al, *Raising the bar for youth suicide prevention: Appendix 1 – Evidence review youth suicide prevention (2016)*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

¹⁷¹ J Robinson et al, 'Can an internet-based intervention reduce suicidal ideation, depression and hopelessness among secondary school students: Results from a pilot study,' *Early Intervention in Psychiatry*, 10(1), 28-35

¹⁷² Robinson J et al, *Looking the Other Way: Young people and self-harm*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 43.

¹⁷³ J Robinson et al, *Raising the bar for youth suicide prevention: Appendix 1 – Evidence review youth suicide prevention (2016)*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

- State government departments and authorities will need to work together, as well as separately, to prevent and reduce suicide by children and young people; and
- sharing information to effectively identify children and young people at risk of suicide and inter-agency collaboration to prevent and reduce suicide by children and young people who experience multiple risk factors and are known to multiple State government departments is of importance.

Since the 2014 Investigation, other Australian State and Territory government agencies have:

- conducted an online survey to consult children and young people who had thought about, planned or attempted suicide ... [about] their experiences of seeking and getting support¹⁷⁴ and inform the development of improved suicide prevention responses for children and young people (Queensland);
- identified similar patterns, trends and groupings of children and young people who have died by suicide (New South Wales¹⁷⁵ and South Australia¹⁷⁶);
- proposed evidence-based intervention and suicide prevention strategies relevant to different groups of young people informed by child death reviews (South Australia);¹⁷⁷
- partnered with the community to develop and introduce a long-term, developmentally informed early intervention approach for socio-economically disadvantaged children and young people (Queensland);¹⁷⁸ and
- established multi-disciplinary teams to deliver intensive home-based 'tertiary level mental health and drug and alcohol interventions for parents and early intervention for children [of parents experiencing mental health, drug or alcohol issues]' (New South Wales).¹⁷⁹

11. Patterns and trends in contact between the children and young people who died by suicide and public services

As part of the 2020 Investigation, the Office utilised the methodology developed during the 2014 Investigation to again consider the patterns and trends in contact and service provision to the children and young people by public health services, the Department of Communities and the Department of Education.

¹⁷⁴ Scott J et al, *Research Summary: Suicide in children and adolescents in Queensland 2004-2015*, Queensland Family & Child Commission, viewed 26 October 2019, <<https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/research/research-summaries/research-summary-suicide-of-young-people-in-Queensland.pdf>>.

¹⁷⁵ Wolf M, Child Death Review Team, NSW Ombudsman, *Submission No. 45 to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW*, August 2017, viewed 26 October 2019, <<https://www.parliament.nsw.gov.au/ladocs/submissions/58726/Submission%2045%20-%20Child%20Death%20Review%20Team,%20NSW%20Ombudsman.PDF>>, pp. 8-9.

¹⁷⁶ Government of South Australia, Child Death and Serious Inquiry Review Committee, *Suicide Prevention and Child Death Review*, 10 October 2018, viewed 26 October 2019, <<http://www.cdsirc.sa.gov.au/>>.

¹⁷⁷ Government of South Australia, Child Death and Serious Inquiry Review Committee, *Suicide Prevention and Child Death Review*, 10 October 2018, viewed 26 October 2019, <<http://www.cdsirc.sa.gov.au/>>.

¹⁷⁸ 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-qlc-submission-on-youth-justice-strategy-se.aspx>>, pp. 2-3.

¹⁷⁹ 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>>.

11.1 Patterns and trends in contact between the children and young people who died by suicide and public health services

During the 2014 Investigation, the Office's examination of referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for 12 young people who were recorded as having been diagnosed with a mental illness found differences between the experiences of the young people in Group 1 and Group 2, particularly with respect to acceptance of referrals by CAMHS and risk assessments.

Since the 2014 Investigation, significant legislative, policy and structural reform has occurred in the Western Australian public health system. On 1 July 2016, the *Hospitals and Health Services Act 1927* was replaced by the *Health Services Act 2016*, which, according to the Department of Health:

- reshaped the role of the Department of Health as 'system manager'¹⁸⁰, with responsibility for strategic planning, safety and quality monitoring, system-wide industrial relations, contracting with health entities and entering into service agreements with health service providers; and
- established five new Health Service Providers as separate statutory authorities, each of which is 'legally responsible for the delivery of health services for their local areas and communities'.¹⁸¹

Collectively, the separate entities now operating as part of the Western Australian public health system are known as **WA Health**.

As a result of these changes, the former 'CAMHS' considered in the 2014 Investigation has transitioned from being part of the Department of Health to part of the new, stand alone Child and Adolescent Health Service (**CAHS**). However, Child and Adolescent Mental Health Services (that is, public mental health care for children and young people) are provided by both CAHS and the Western Australian Country Health Service (**WACHS**).¹⁸²

According to CAHS, it 'provides a comprehensive service supporting the health, wellbeing and development of young Western Australians'¹⁸³ through three service directorates:

- Child and Adolescent Health Service - Community Health (known as Child and Adolescent Community Health (**CACH**) prior to 1 July 2018);
- Child and Adolescent Health Service – Child and Adolescent Mental Health Services (**CAHS CAMHS**); and
- Perth Children's Hospital.

¹⁸⁰ Department of Health, *Health Reform Fact Sheet: The Role of the Department of Health*, Government of Western Australia, Perth, 2016, viewed 9 September 2018, <<https://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Health%20Reform/The-Role-of-the-Department-of-Health-Fact-Sheet.pdf>>, p. 1.

¹⁸¹ Department of Health, *Health Reform Fact Sheet: The Health Services Act 2016: A Snapshot*, Government of Western Australia, Perth, 2016, viewed 9 September 2018, <<https://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Health%20Reform/Fact%20Sheet%20-%20The%20Health%20Services%20Act%202016%20-%20Snapshot.pdf>>, p. 2.

¹⁸² Both health service providers were established under clause 12(1) of the *Health Services (Health Service Providers) Order 2016* as published in the Government Gazette dated 17 June 2016.

¹⁸³ Government of Western Australia Department of Health, *Child and Adolescent Health Service*, Government of Western Australia, Perth, 2018, viewed 9 September 2018, <<https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service>>.

CAHS provides both inpatient and community based mental health services for children and young people. The CAHS Perth Children's Hospital is commissioned to provide a 20-bed inpatient mental health unit for children and young people up to 16 years, and is also the location of the following specialist services:

- **Mental Health Inpatient Unit**, Ward 5A. WA's only Authorised Mental Health Inpatient Unit for patients aged 0 to 16;
- **Statewide Eating Disorder Service**, which provides an outpatient and day program for children and young people with eating disorders;
- **Statewide Gender Diversity Service**, which provides assessment, care and treatment of gender diversity related issues, including assessment and approval for medical intervention in teenagers;¹⁸⁴
- **Paediatric Consultation Liaison**, which provides support for children and adolescents who are patients at Perth Children's Hospital and have mental health issues relating to their medical conditions or their treatment plan;¹⁸⁵ and
- **Mental Health Support Line**.

There are 10 Community CAHS Child and Adolescent Mental Health Services (known as **CAMHS**) sites across the metropolitan area: Armadale, Bentley Family Clinic, Clarkson, Fremantle, Hillarys, Peel, Rockingham, Shenton, Swan and Warwick. These services are commissioned to provide services to children and young people up to the age of 18 years.

- **Pathways** – a day program for children aged 6 to 12. Pathways Therapeutic Day Program is an evidence-based Tier 4 service providing educational and therapeutic services in an integrated manner to children with complex educational, social behavioural, emotional and mental health issues. Referrals come from Tier 3 services such as [Community] CAMHS, Child Development Services and other specialised health services for children.
- **Touchstone** – a day program for adolescents aged 12 to 17 years and their families. The therapy program offers an evidence-based intervention to help young people that are struggling to cope with relationships, mood difficulties and impulsive self-harming behaviours such as cutting.
- **Multisystemic Therapy** – for children aged 12 to 16 years with anger, violence and/or antisocial behaviour. May have co-morbid alcohol and other drug use and issues with school or employment due to behaviour.

WACHS provides community based CAMHS in each of its seven regions, including two small specialist youth mental health services, funded by the Mental Health Commission. However, in rural and remote areas there are no inpatient facilities for children and young people. Accordingly, WACHS provides only community based mental health services for children and young people.

¹⁸⁴ Department of Health, *Child and Adolescent Health Service – Mental Health PCH Mental Health*, CAHS, Perth, viewed 9 September 2018, <<https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Mental-Health-Service/Our-services/PCH-Mental-Health>>.

¹⁸⁵ Department of Health, *Child and Adolescent Health Service – Mental Health PCH Mental Health*, CAHS, Perth, viewed 9 September 2018, <<https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Mental-Health-Service/Our-services/PCH-Mental-Health>>.

In this report, the mental health services provided by CAHS and WACHS to children and young people will be referred to, respectively, as **CAHS CAMHS** and **WACHS CAMHS**.

Additional specialist 'youth mental health' inpatient units for young people and young adults ages 16 to 24 years are operated by the East Metropolitan and South Metropolitan Health Services, but these health service providers do not have any corresponding youth mental health community services.

The North Metropolitan Health Service also has a Youth 'Hospital in the Home' for 16 to 24 year olds as part of its Youth Mental Health Program (which also includes YouthLink, YouthReach South, YouthAxis, Youth and Adult Complex Attentional Disorders Service and a Gender Pathways Service).

Since the 2014 Investigation, CAHS CAMHS and WACHS CAMHS have also implemented a new service delivery model known as the 'Choice and Partnership Approach' (**CAPA**). CAPA differs from the 'traditional' approach of screening, assessment of appropriateness for treatment and referral to specialist interventions and clinicians. Instead, under CAPA expertise is 'front-loaded', with specialist staff meeting 'newly referred children and their families ... [at] an early stage of the care process'¹⁸⁶ CAPA works flexibly with families, who 'are offered a choice of day, time and venue' and aims to ensure 'fast access to effective care and [a reduced] need for repeat assessments.'¹⁸⁷

The Chief Psychiatrist reviewed WACHS' mental health services between May to July 2016, and noted in his 2017-18 Annual Report that:

The review identified five areas of notable practice:

- Mental health assessment
- Contact details for a variety of supports
- Physical healthcare – metabolic monitoring
- Discharge/transfer of care – clarification of accommodation
- Balancing confidentiality with carer involvement.

Seven recommendations were made, in the areas of drug and alcohol screening, physical examination of inpatients, risk assessment, patient involvement and discharge planning.¹⁸⁸

CAHS CAMHS was reviewed in May 2017, including all 10 community CAMHS in the metropolitan area, six specialist CAMHS services and the Bentley Adolescent Inpatient Unit.¹⁸⁹ During this investigation, the Chief Psychiatrist informed the Office that his:

... Clinical Monitoring and Service Review Report for CAHS CAMHS looked at the extent to which risk assessments were undertaken and whether they were consistent with the Chief Psychiatrists Standards for Clinical Care – Risk

¹⁸⁶ Coulter N, *The Choice and Partnership Approach (CAPA) – A model for mental health service transformation*, viewed 6 May 2019, <<http://www.qihub.scot.nhs.uk/media/505188/the%20choice%20and%20partnership%20approach%20ann%20york.pdf>>.

¹⁸⁷ Coulter N, *The Choice and Partnership Approach (CAPA) – A model for mental health service transformation*, viewed 6 May 2019, <<http://www.qihub.scot.nhs.uk/media/505188/the%20choice%20and%20partnership%20approach%20ann%20york.pdf>>.

¹⁸⁸ Chief Psychiatrist of Western Australia, *Annual Report 2016-17*, Chief Psychiatrist of Western Australia, September 2017, viewed 6 December 2019, <[https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4010721a2fe8c79a2a4a8bdb482581b5002a444c/\\$file/721.pdf](https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4010721a2fe8c79a2a4a8bdb482581b5002a444c/$file/721.pdf)>, p. 43.

¹⁸⁹ Chief Psychiatrist of Western Australia, *Annual Report 2016-17*, Chief Psychiatrist of Western Australia, September 2017, viewed 6 December 2019, <[https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4010721a2fe8c79a2a4a8bdb482581b5002a444c/\\$file/721.pdf](https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4010721a2fe8c79a2a4a8bdb482581b5002a444c/$file/721.pdf)>, p. 44.

Assessment Standard. We found that CAHS CAMHS services consistently undertook risk assessments of children accepted by CAMHS, when they were first assessed.

The Office again considered mental health service provision to the children and young people who died by suicide as part of the 2020 Investigation, using a sample of 36 children and young people (of the 79 children and young people) for whom a child death review was conducted and records from WA Health were obtained.

Of these 36 children and young people 19 had contact with a CAHS CAMHS or WACHS CAMHS in the last year of their lives. Included within this cohort of 19 young people were 12 young people died while receiving services from CAHS CAMHS or WACHS CAMS, or within one month of being discharged from these services (63 per cent). A further five young people died prior to receiving any CAMHS services.

The Office also considered CAMHS's communication with referrers when child or young person was not accepted, or was closed or discharged from a CAMHS provider in seven of the above 19 child death reviews. These child death reviews indicated that professionals or organisations referring children and young people to CAMHS were not being notified of that referrals non-acceptance or closure in 71 per cent of cases.

The Office has noted the ongoing relatively low proportion of children and young people who died by suicide and likely experienced cumulative harm arising from multiple incidents and types of abuse and/or neglect referred to or receiving mental health services. The research literature observes that 'traditional mental health diagnoses often do not adequately capture the effects of chronic and/or multiple types of victimisation ... [known as] complex trauma and cumulative harm' which may often require 'more comprehensive intervention and treatment' than a single incident of maltreatment.¹⁹⁰

In particular, the Office observed that Aboriginal children and young people who died by suicide were less likely to have been diagnosed with a mental illness despite being overrepresented amongst the cohort of children and young people who died by suicide and experienced multiple factors associated with suicide (Group 1).

Accordingly, the Office will continue to monitor referrals, assessment and service provision to children and young people who die by suicide via its child death reviews.

11.2 Patterns and trends in contact between the children and young people who died by suicide and the Department of Communities' child protection services

As the Office observed in the 2014 Investigation, the research literature identifies 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

¹⁹⁰ R Price-Robinson et al, 'Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma', *Child Family Community Australia Paper No. 15*, CFCA, June 2013.

issues.¹⁹¹ ¹⁹² Children and young people in out of home care are recognised as 'particularly vulnerable and often experience significant risk factors and unmet need'.¹⁹³

In addition, the research literature identifies that adverse family experiences (also known as 'adverse childhood experiences' or 'ACEs'), such as chronic abuse and/or neglect, increase the risk of attempted suicide. Adverse childhood experiences are defined as 'acts of commission or omission by a parent or other caregiver that result in harm, potential for harm or threat of harm to a child in the first 18 years of life, even if harm is not the intended result'.¹⁹⁴

The research literature notes that effective responses to adversity experienced by older children and young people (above the age of 7 years) can be limited by 'the way agencies understand and deal with older children's problems', 'less obvious' indicators of neglect in older children, an increased prevalence of issues 'such as self-harm or offending behaviour ... exposure to child sexual exploitation ... gang-related activity or violence' amongst this cohort, and the idea that older children are 'choosing a lifestyle' or 'resilient' and 'do not need help'.¹⁹⁵

Statutory child protection services, such as those provided by the Department of Communities, frequently deal with children and young people at risk of suicide and play a key role in assessing their safety and development, providing services, and linking them with appropriate support and mental health services. However, the research literature also notes that Australian statutory child welfare services are struggling to fully implement a cumulative harm approach to their work in a service delivery environment where the prevalence of repeated instances of abuse and trauma is much greater than previously estimated, with:

- one in 35 children and young people in Australia receiving child protection services;¹⁹⁶ and
- one in four children under the age of 10 reported to child protection authorities, 90 per cent of whom were the subject of multiple alleged instances of abuse and neglect.¹⁹⁷

Of the 50 children and young people in Group 1 in the 2020 Investigation, records indicate that 39 (78 per cent) allegedly experienced more than one form of child abuse or neglect,

¹⁹¹ World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 36.

¹⁹² Bendall S et al, *Trauma and young people. Moving toward trauma-informed services and systems*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2018, viewed 26 October 2019, <[https://www.orygen.org.au/Policy/Policy-Reports/Trauma-and-young-people-Moving-toward-trauma-info/Orygen_trauma_and_young_people_policy_report?ext=.>](https://www.orygen.org.au/Policy/Policy-Reports/Trauma-and-young-people-Moving-toward-trauma-info/Orygen_trauma_and_young_people_policy_report?ext=.), pp. 18-19.

¹⁹³ Wolf M, Child Death Review Team, NSW Ombudsman, *Submission No. 45 to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW*, August 2017, viewed 26 October 2019, <<https://www.parliament.nsw.gov.au/ladocs/submissions/58726/Submission%2045%20-%20Child%20Death%20Review%20Team,%20NSW%20Ombudsman.PDF>>, pp. 9-10.

¹⁹⁴ Von Cheong E et al, 'Adverse childhood experiences (ACEs) and later-life depression: perceived social support as a potential protective factor', *BMJ Open*, vol. 7, no. 9, 2017, e:013228.

¹⁹⁵ Ofsted, Care Quality Commission, HMI Constabulary and Fire & Rescue Services and HMI Probation, *Growing up neglected: a multi-agency response to older children*, July 2018, viewed 26 October 2019, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722740/Older_childr_en_neglect_FINAL_060718.pdf> .

¹⁹⁶ Defined as those children who, after being the subject of a notification to a child protection authority, were the subject of an investigation, a protection order or an out of home care placement.

¹⁹⁷ Puddy R, 'Australia facing an "epidemic of abuse and neglect", according to experts', *ABC News*, 16 September 2018, viewed 26 October 2019, <<https://www.abc.net.au/news/2018-09-16/australia-facing-an-epidemic-of-child-abuse-and-neglect/10233898>>.

and therefore are likely to have suffered cumulative harm. The pattern of child abuse or neglect among these 39 children and young people was as follows:

- 11 children and young people (22 per cent) allegedly experienced one type of child abuse or neglect;
- 8 children and young people (16 per cent) allegedly experienced two types of child abuse or neglect;
- 10 children and young people allegedly (20 per cent) experienced three types of child abuse or neglect;
- 16 children and young people (32 per cent) allegedly experienced four types of child abuse or neglect;
- 5 children and young people (10 per cent) allegedly experienced all five types of child abuse or neglect.

These children and young people most commonly experienced neglect (37 of the 50 children and young people) and exposure to family and domestic violence (36 of the 50 children and young people). Approximately half had additionally survived alleged physical abuse (24 of the 50 children and young people) and/or alleged sexual abuse (22 of the 50 children and young people).

Through fieldwork conducted during the 2020 Investigation, the Office identified that the Department of Communities received information raising concerns about the wellbeing of 47 of these 50 children and young people on 658 occasions, in the form of a recorded 'interaction'. On average, these 47 children and young people came to the attention of the Department of Communities 14 times, with the number of instances where concerns were raised for each individual child or young person ranging from one to 70 occasions.

However, the concerns about the wellbeing of these children and young people was not always recorded as a 'child protection' concern. The Office identified 103 interactions in which the Department of Communities instead recorded the receipt of information alleging abuse, harm or neglect of a child or young person as 'family support', 'practical problem' or 'other crisis issue'. Concerns of neglect and emotional abuse were most frequently recorded as a 'family support' issue instead of a 'child protection' concern, comprising 86 of the total 118 'family support' interactions (73 per cent). The Office notes that similar recording issues in the proportion of 'child protection' concerns and 'family support' interactions were observed in Prudence Ford's 2007 *Review of the Department of Community Development*.¹⁹⁸

For the majority of these 658 interactions (492 interactions, or 75 per cent) the Department of Communities either took 'no further action' or did not progress past the 'initial inquiry'.

- Initial inquiries to clarify information received were made on 105 occasions (16 per cent) in relation to 35 children and young people (74 per cent).
- A safety and wellbeing assessment (now known as child safety investigations) to ascertain whether a child or young person had been harmed, was at risk of harm, and/or in need of protection, occurred on 76 occasions (12 per cent). However, harm was

¹⁹⁸ Ford P, *Review of the Department for Community Development: Review Report*, Government of Western Australia, Perth, January 2007, p. 34.

substantiated in 37 per cent (28) of these investigations, with children and young people brought into the care of the CEO in 57 per cent of substantiated cases (16 occasions, relating to 8 of the 47 children and young people).

Subsequent concerns about a child or young person raised after a safety and wellbeing assessment were even less likely to result in a Departmental response. Of the 96 occasions where additional concerns for a child or young person's wellbeing were raised following the completion of a safety and wellbeing assessment:

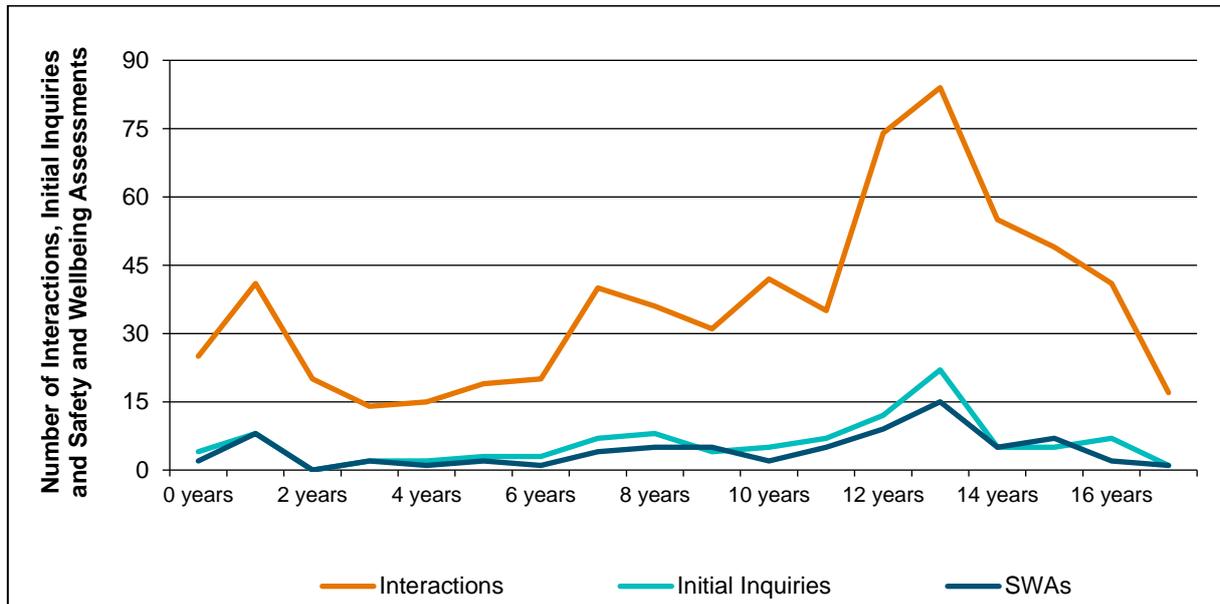
- no further action was taken in response to the majority of concerns (69 per cent, 66 occasions); and
- none progressed to a re-consideration of whether the child or young person had experienced harm, was at risk of harm and/or was in need of protection through a second safety and wellbeing assessment.

As discussed in Chapter 6 of Volume 3, Aboriginal children and young people continue to be the subject of higher levels of contact and involvement with the Department of Communities. The Office's analysis of the 47 children and young people in Group 1 who allegedly experienced child abuse or neglect and were known to the Department of Communities, identified that 27 were Aboriginal and 20 were non-Aboriginal;

- 485 of the 658 interactions the Department of Communities received for children and young people in Group 1, related to the 27 Aboriginal children and young people in this group (74 per cent); and
- 23 of the 27 Aboriginal children and young people in Group 1 were the subject of initial inquiries or a safety and wellbeing assessment conducted by the Department of Communities (85 per cent), compared to 11 of the 20 non-Aboriginal children and young people (55 per cent).

The Office also considered the ages at which concerns for the 47 children and young people were reported to, and considered by, the Department of Communities as shown in Figure 11:

Figure 11: Department of Communities responses to the 47 children and young people in Group 1 of the 2020 Investigation alleged to have experienced abuse and/or neglect, by age at time of contact



Source: Ombudsman Western Australia

The Office's analysis also found that the greatest number of interactions, initial inquiries and safety and wellbeing assessments for the 47 children and young people in Group 1 of the 2020 Investigation occurred between the ages of 12 to 14. The Office notes the recent steps proposed by the Department of Communities to improve safety and wellbeing assessments undertaken by child protection officers as detailed in Chapter 2.12 of Volume 2 and will continue to monitor these issues.

Utilising the above mentioned data from the Department of Communities' contact with 47 of the 50 children and young people in Group 1, the Office also conducted a new analysis of the Department's response to suicidal and self-harming behaviours in children, young people and their families. The Office found that 41 of the 658 interactions relating to the 47 children and young people in Group 1 of the 2020 Investigation contained concerns about suicidal and self-harming behaviours relating to a child or young person that died by suicide, their sibling or parent/caregiver. Fifteen of these interactions occurred during the 2020 Investigation, as summarised in Table 8. Nine of these interactions included additional concerns that the parents/caregivers of a suicidal child or young person was unable or willing to provide adequate care for the child or young person.

Table 8: Interactions for the for the 47 children and young people in Group 1 known to the Department of Communities that included concerns relating to suicidal or self-harming behaviours

	Interactions that occurred before tabling of the 2014 Investigation	Interactions that occurred during the 2020 Investigation	Total
Suicide attempt of child, young person or their sibling/other child relative aged under 18 years			
	9	8	17
Communicated suicidal intention or suicidal ideation of child or young person			
	5	3	8
Self-harming behaviour of child or young person			
	4	2	6
Child or young person who witnessed suicidal behaviour of parent or caregiver			
	4	0	4
Concerns for child or young person's wellbeing after parent or caregiver suicidal behaviour or ideation			
	4	2	6
Total	26	15	41

Source: Ombudsman Western Australia

Across the 41 interactions reporting suicidal and self-harming behaviour during the 2014 and 2020 Investigation periods, the Office noted that these concerns were not consistently assessed in accordance with the relevant Casework Practice Manual guidance.

For the above reasons, the Ombudsman has made the following recommendation:

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.

11.3 Patterns and trends in contact between the children and young people who died by suicide and the Department of Education

The research literature identifies that educational institutions have an important role to play in preventing and reducing suicide by children and young people.¹⁹⁹ Schools may also be the first to identify behavioural problems that often precede 'a mental, emotional or behavioural disorder by two to four years'²⁰⁰ and facilitating access to early mental health interventions, parenting programs and initiatives promoting resilience and pro-social behaviour.²⁰¹

As set out in Chapters 2.15 to 2.21 of Volume 2, the Department of Education has made a range of changes to its policies and procedures since the 2014 Investigation, including in relation to student behaviour, student attendance and identifying and responding to children and young people allegedly experiencing abuse or neglect or being at risk of self-harming or suicidal behaviours.

The Office obtained school attendance records from the Department of Education for the 50 children and young people in Group 1 that died by suicide during the 2020 Investigation:

- 49 of the 50 young people (98 per cent) in Group 1 attended a public school at some time during their lives; and
- 38 of the 49 children and young people (78 per cent) in Group 1 were enrolled at a public school during the last year of their life, and required to be regularly attending school.

For those 38 children and young people enrolled at a public school during the last year of their life, their attendance during that last year ranged from 0 to 98.7 per cent. However, of those 38 children and young people, 23 (60 per cent) had attendance below 60 per cent and were at 'severe educational risk' under the Department of Education's *Managing Student Attendance in Western Australian Public Schools* policy.

Of these 38 children and young people, 20 were Aboriginal. School attendance records indicate that the majority were also at 'severe educational risk', as follows:

- 12 (60 per cent) attended school less than 60 per cent of the time in the last year of their life;
- 4 (20 per cent) attended school between 60 and 70 per cent of the time in the last year of their life;
- 4 (20 per cent) attended between 80 and 89 per cent of the time in the last year of their life; and
- none had school attendance rates of less than 8 per cent, or above 90 per cent.

¹⁹⁹ World Health Organization, *Preventing Suicide: A resource for teachers and other school staff*, WHO, Geneva, 2000, viewed 26 October 2019, <https://www.who.int/mental_health/media/en/62.pdf>, p. 6.

²⁰⁰ The Royal Australian and New Zealand College of Psychiatrists, *Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning strategies for Australia and New Zealand*, Faculty of Child and Adolescent Psychiatry, RANZCP, Melbourne, 2010, viewed 26 October 2019, <<https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx>>, p. 4.

²⁰¹ The Royal Australian and New Zealand College of Psychiatrists, *Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning strategies for Australia and New Zealand*, Faculty of Child and Adolescent Psychiatry, RANZCP, Melbourne, 2010, viewed 26 October 2019, <<https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx>>, p. 11.

In the course of the Ombudsman's child death reviews, the Department of Education has identified a number of gaps in relation to attendance intervention relating to some of these children and young people and undertaken to address these.

Of the 49 children and young people in Group 1 who had attended a public school during their lives ten (20 per cent) had previously been suspended for more than 10 days in a school year, three of whom (6 per cent) went on to be suspended for more than 20 days in a school year.

12. Information sharing and inter-agency collaboration

In the 2014 Investigation, the Office identified the importance of State government departments and authorities:

- sharing information to facilitate the effective identification of young people at risk of suicide; and
- making a collaborative effort to prevent and reduce suicide by young people who experience multiple risk factors associated with suicide and have contact with multiple State government departments.

The research literature identifies that challenging behaviours exhibited by children and young people experiencing cumulative harm are often not understood in the context of trauma.²⁰²

Since the 2014 Investigation, some other jurisdictions have introduced 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'²⁰³ or have parents experiencing mental health, drug or alcohol issues.²⁰⁴ Others have introduced long-term early intervention initiatives to reduce rates of developmentally vulnerable children and young people in areas of socio-economic disadvantage.²⁰⁵

²⁰² Ofsted, Care Quality Commission, HMI Constabulary and Fire & Rescue Services and HMI Probation, *Growing up neglected: a multi-agency response to older children*, July 2018, viewed 26 October 2019, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722740/Older_child_en_neglect_FINAL_060718.pdf> pp. 8-10.

²⁰³ 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/>>.

²⁰⁴ 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>>.

²⁰⁵ Royal Australian and New Zealand College of Psychiatrists, *Submission to the Legal and Social Issues Committee's Inquiry into youth justice centres in Victoria*, 21 September 2018, viewed 26 October 2019, <<https://www.ranzcp.org/files/resources/submissions/ranzcp-qld-submission-on-youth-justice-strategy-se.aspx>>, pp. 2-3.

Trauma informed service delivery and inter-agency collaboration both require a foundation of effective information sharing mechanisms. The research literature identifies that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help',²⁰⁶ and agencies face challenges in providing services to these young people.²⁰⁷ The majority of children and young people who died by suicide in Western Australia between 1 July 2009 and 30 June 2018 were in Group 1 (79 children and young people, 69 per cent), many of whom were characterised as 'hard to help'.

In the 2014 Investigation, the Office also identified that preventing or reducing suicide among the children and young people who experience multiple risk factors for suicide requires intervention across a range of State government departments and authorities. The Office also suggested that, given the frequency of contact between children and young people in Group 1 and public mental health services, child protection services and public schools, coordination of support through a case management approach could be effective.

The Office noted that one example of a case management approach for at-risk young people was the Young People with Exceptionally Complex Needs program (**the YPECN program**) which, in 2012, had the capacity to support up to 10 young people for a period of up to two years.

Since the 2014 Investigation, the YPECN program has been expanded to support 14 young people. The Mental Health Commission, Department of Health, Department of Communities and Department of Education have also formed an Interagency Executive Committee to consider the development of a collaborative inter-agency approach for children and young people with multiple risk factors for suicide and a joint case management approach.

Changes to the *Children and Community Services Act 2004*, effective since 1 January 2016, have also established a legislative framework and legal protections, enabling prescribed State government departments and authorities 'to share information that is relevant to the wellbeing of a child or children directly with one another ... prescribed non-government providers and non-government schools.'²⁰⁸ The definition of 'relevant information' has also been 'broadened to include information that is relevant to the safety of persons subjected or exposed to family and domestic violence.'²⁰⁹

²⁰⁶ Brandon M et al, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

²⁰⁷ Brandon M et al, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

²⁰⁸ Department for Child Protection and Family Support, *New information-sharing laws under the Children and Community Services Act 2004 (WA) – section 28B*, 2015, viewed 6 October 2019, <<https://www.dcp.wa.gov.au/Organisation/Documents/Implementation%20information%20for%20the%20non%20government%20sector.pdf>>, p. 1.

²⁰⁹ Department for Child Protection and Family Support, *New information-sharing laws under the Children and Community Services Act 2004 (WA) – section 28B*, 2015, viewed 6 October 2019, <<https://www.dcp.wa.gov.au/Organisation/Documents/Implementation%20information%20for%20the%20non%20government%20sector.pdf>>, p. 1.

However, the research literature has observed an ongoing 'lack of collaboration and information sharing between agencies' and need for a 'coordinated and integrated information system for children and adolescents at high risk is needed to ensure effective communication between multiple agencies working on the same case.'²¹⁰

Further reform to information sharing in Western Australia is currently underway, with the State government's *Privacy and Responsible Information Sharing for the Western Australian Public Sector Discussion Paper* outlining a proposal to introduce 'a clear, overarching information-sharing framework' to 'assist with the delivery of 'joined up' government services.'²¹¹

Accordingly, for the above reasons, the Ombudsman has made the following recommendation:

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.

²¹⁰ Telethon Kids Institute and Menzies School of Health Research, *Submission No. 18 to the Education and Health Standing Committee Inquiry into Aboriginal youth suicide in remote areas*, Legislative Assembly, Parliament of Western Australia, Perth, 24 May 2016, p. 5.

²¹¹ Western Australian Government, *Privacy and Responsible Information Sharing for the Western Australian Public Sector Discussion Paper*, 2019, p. 33.

Major Investigations and Reports

Title	Date
<u><i>A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce deaths of children by drowning</i></u>	November 2018
<u><i>Investigation into ways to prevent or reduce deaths of children by drowning</i></u>	November 2017
<u><i>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</i></u>	November 2016
<u><i>Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities</i></u>	November 2015
<u><i>Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people</i></u>	April 2014
<u><i>Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths</i></u>	November 2012
<u><i>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</i></u>	November 2011
<u><i>The Management of Personal Information - good practice and opportunities for improvement</i></u>	March 2011
<u><i>2009-10 Survey of Complaint Handling Practices in the Western Australian State and Local Government Sectors</i></u>	June 2010

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