



**A report on the steps taken to give effect to the  
recommendations arising from *Preventing suicide by  
children and young people 2020***

**Ombudsman Western Australia**  
Serving Parliament – Serving Western Australians

## About this Report

This Report is available in print and electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with disability. Requests should be directed to the Publications Manager.

Requests to reproduce any content from this Report should be directed to the Publications Manager. Content must not be altered in any way and Ombudsman Western Australia must be acknowledged appropriately.

## Contact Details

### Street Address

Level 2, 469 Wellington Street  
PERTH WA 6000

### Postal Address

PO Box Z5386 St Georges Terrace  
PERTH WA 6831

**Telephone:** (08) 9220 7555 or 1800 117 000 (free from landlines)

**Translating and Interpreting Service (TIS National):** 131 450  
(for people who need an interpreter)

**National Relay Service Helpdesk:** 1800 555 660 (quote 08 9220 7555)  
(for people with a voice or hearing impairment)

**Email:** [mail@ombudsman.wa.gov.au](mailto:mail@ombudsman.wa.gov.au)

**Web:** [www.ombudsman.wa.gov.au](http://www.ombudsman.wa.gov.au)

**ISBN (Print):** 978-0-6450318-2-9

**ISBN (Online):** 978-0-6450318-3-6

First published by Ombudsman Western Australia in September 2021.

## 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 or Torres Strait Islander children and young people who died by suicide.

**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.**

**We acknowledge the Whadjuk Noongar people as the traditional custodians of the land on which the office of the Ombudsman is located.**

This page has intentionally been left blank.

## Contents

<b>1</b>	<b>About the report</b> .....	<b>11</b>
1.1	The Ombudsman.....	11
1.2	Own motion investigations.....	15
1.3	Steps taken to give effect to recommendations of the Ombudsman .....	15
1.4	<i>Preventing suicide by children and young people 2020</i> .....	15
1.5	A report on the steps taken to give effect to the recommendations arising from the Report .....	17
<b>2</b>	<b>Steps taken to give effect to the recommendations</b> .....	<b>19</b>
2.1	Recommendation 1 .....	19
2.2	Recommendation 2 .....	25
2.3	Recommendation 3 .....	29
2.4	Recommendation 4 .....	33
2.5	Recommendation 5 .....	37
2.6	Recommendation 6 .....	41
2.7	Recommendation 7 .....	47

This page has been intentionally left blank.

## 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  
provides phone and online videocall support for children and young people experiencing a mental health crisis as well as support and advice to families and carers, 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](https://suicidecallbackservice.org.au)  
free phone, video and online counselling for people at risk of suicide, concerned about someone at risk, bereaved by suicide and people experiencing emotional or mental health issues

**Lifeline:** 13 11 14 or [lifeline.org.au](https://lifeline.org.au)  
24 hour telephone crisis support and suicide prevention  
online crisis support chat available from 7PM to midnight AEST

**Beyond Blue:** 1300 22 4636 or [beyondblue.org.au](https://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/](https://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](https://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](https://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](http://dhys.org.au)

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

**Social and Emotional Wellbeing and Mental Health Service:** [sewbmh.org.au](http://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](http://sane.org)

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

**GriefLine:** 1300 845 745 (landlines) or (03) 9935 7400 (mobiles) or [griefline.org.au](http://griefline.org.au)

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

**Embrace Multicultural Mental Health:** [embracementalhealth.org.au](http://embracementalhealth.org.au)

provides culturally accessible resources, services and information on mental health and suicide prevention for people from culturally and linguistically diverse backgrounds

**QLife:** 1800 184 527 or [qlife.org.au](http://qlife.org.au)

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

**MindOUT!:** [lgbtihealth.org.au/mindout](http://lgbtihealth.org.au/mindout)

provides workforce and community resources and education for LGBTIQ+, other sexuality, sex and gender diverse people

**1800RESPECT:** 1800 737 732 or [1800respect.org.au](http://1800respect.org.au)

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

**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 Ombudsman, I have an important responsibility to review child deaths. Arising from my responsibility to review child deaths, I undertook a major own motion investigation, *Preventing suicide by children and young people 2020 (the Investigation)*, tabled in Parliament on 24 September 2020. Arising from my findings in the Investigation, I made seven recommendations about ways to prevent or reduce deaths of children and young people by suicide. The Mental Health Commission, Department of Health, Department of Communities and Department of Education each agreed to these recommendations.

In 2016-17, I gave a commitment to Parliament that, following the tabling of each major own motion investigation, my Office would undertake a comprehensive review of the steps taken by government agencies to give effect to our recommendations and then table the results of this review in Parliament twelve months after the tabling of the major own motion investigation. Accordingly, I am now pleased to provide Parliament with *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020*, September 2021.

I am very pleased to report to Parliament that in relation to the recommendations I have found that steps have been taken, and are proposed to be taken, to give effect to the recommendations. In no instance have I found that no steps have been taken to give effect to the recommendations.

In undertaking the review of the steps taken by the agencies to give effect to the recommendations, it is very evident to me that there is a particularly positive and very pleasing emphasis on strong cooperation and collaboration between the agencies. This is vitally important as the tragedy of suicide by children and young people cannot be prevented by a single program, service or agency working in isolation. Accordingly, I take this opportunity to commend and thank the Mental Health Commission, Department of Health, Department of Communities and Department of Education on this approach.

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

Finally, I extend my deepest personal sympathy and condolences to all Western Australian families, friends, students and communities impacted by the tragic and immeasurable loss of life of a child or young person by suicide. It is my sincerest hope that the recommendations of the Investigation, and the very positive steps that have been taken, and are proposed to be taken, by the four government agencies to give effect to the recommendations, will contribute to preventing these tragic deaths in the future.

Chris Field  
**OMBUDSMAN**

This page has been intentionally left blank.

# 1 About the report

## 1.1 The Ombudsman

### 1.1.1 The role of the Ombudsman

The Ombudsman is an officer of the Western Australian Parliament. The Ombudsman is independent of the government of the day and completely impartial. The Ombudsman has functions in relation to:

- the investigation of State government departments, statutory authorities, boards and corporations, local governments and universities;
- the review of child deaths and family and domestic violence fatalities; and
- a number of other investigatory, review and oversight functions, provided for in a range of legislation.

The Ombudsman can undertake investigations regarding the decision making of public agencies on reference by Parliament, arising from a complaint or of her or his own motion.

In undertaking an investigation, the Ombudsman has the rights, privileges and responsibilities prescribed in the *Parliamentary Commissioner Act 1971 (the Act)* and of a standing Royal Commission (in accordance with the *Royal Commissions Act 1968*).

At the completion of an investigation, the Ombudsman can form opinions and make recommendations. The Ombudsman's report of an own motion investigation is tabled in Parliament and is publicly available.

### 1.1.2 The Ombudsman's child death review function

In November 2001, prompted by the death of a child in 1999, the State government commenced a special inquiry into the response of State government agencies to complaints of family violence and child abuse in Aboriginal communities.

The special inquirer's report, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities* (2002), recommended the establishment of a Child Death Review Team to review the deaths of Western Australian children (Recommendation 146). In response to this report, a Child Death Review Committee (**CDRC**) was formed in January 2003, to review the operation of the former Department for Community Development's policies, procedures and organisational systems.

In August 2006, Ms Prudence Ford commenced an independent functional review of the (then) Department for Community Development and her report, *Review of the Department for Community Development: Review Report (the Ford Report)* was published in January 2007. In considering the need for an independent, inter-agency child death review model, the Ford Report recommended that:

- the CDRC together with its current resources be relocated to the Ombudsman (Recommendation 31); and
- a small specialist investigative unit be established in the Office to facilitate the independent investigation of complaints and enable the further examination, at the discretion of the Ombudsman, of child death review cases where the child was known to a number of agencies (Recommendation 32).

Subsequently, the Act was amended to enable the Ombudsman to undertake child death reviews, and on 30 June 2009, the child death review function in the Office commenced operation.

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. Investigable deaths are defined in section 19A(3) of the Act as follows:

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

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

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

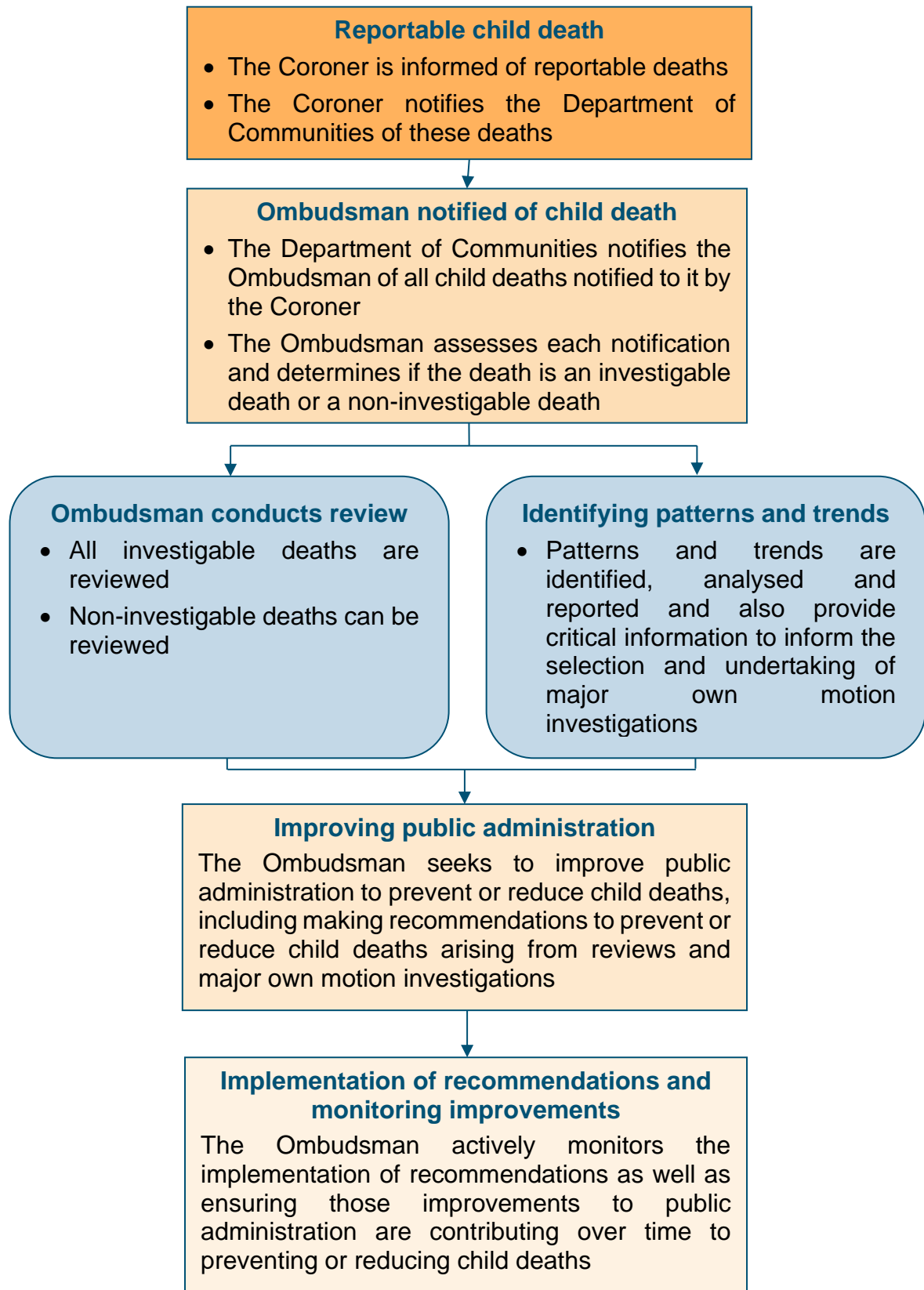
- (a) to review the circumstances in which and why the deaths occurred;
- (b) to identify any patterns or trends in relation to the deaths;
- (c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

In reviewing child deaths, the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child and powers to recommend improvements to public administration about ways to prevent or reduce child deaths across all agencies within the Ombudsman's jurisdiction. The Ombudsman also has powers to monitor the steps that have been taken, are proposed to be taken or have not been taken to give effect to the recommendations.

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.

**Figure 1: The Child Death Review Process**



## **1.2 Own motion investigations**

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

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

## **1.3 Steps taken to give effect to recommendations of the Ombudsman**

### **1.3.1 Monitoring the implementation of recommendations**

The Ombudsman also actively monitors the implementation and effectiveness of recommendations arising from own motion investigations, in accordance with sections 25(4) and (5) of the Act, which state:

- (4) If under subsection (2) the [Ombudsman] makes recommendations to the principal officer of an authority he [or she] may request that officer to notify him [or her], within a specified time, of the steps that have been or 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.
- (5) Where it appears to the [Ombudsman] that no steps that seem to him [or her] to be appropriate have been taken within a reasonable time of his [or her] making any report or recommendations under subsection (2), the [Ombudsman], after considering the comments (if any) made by or on behalf of the principal officer to whom the report or recommendations were made, may, if he [or she] thinks fit, send to the Premier of the State a copy of the report and the recommendations together with a copy of any such comments.

More specifically, twelve months after the tabling of an own motion investigation, the Ombudsman tables a report in parliament on the implementation of the recommendations arising from the own motion investigation. This is done for every own motion investigation.

## **1.4 Preventing suicide by children and young people 2020**

Through the Ombudsman's review of certain child deaths, identification of patterns and trends arising from these reviews and recommendations made about ways to prevent or reduce child deaths, the Ombudsman identified that:

- suicide was the most frequent circumstance of death of young people aged 13 to 17 years notified to the Ombudsman;
- suicide accounted for 16 per cent of all notified child deaths since the commencement of the Ombudsman's child death review function on 30 June 2009; 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**). The 2014 Investigation analysed

36 deaths in which a young person had either died by suicide or was suspected to have died by suicide (**the 36 young people**). The report of the findings and recommendations arising from the 2014 Investigation, titled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, was tabled in the Western Australian Parliament on 9 April 2014. The 2014 Investigation Report is available online at [www.ombudsman.wa.gov.au/suicidebyyoungpeoplereport2014](http://www.ombudsman.wa.gov.au/suicidebyyoungpeoplereport2014)

Following the 2014 Investigation, the Ombudsman further identified from the child death notifications received by the Office that suicide continued to be the leading circumstance of investigable and non-investigable deaths of young people aged 13 to 17 years.

Sadly, the Ombudsman also identified a new trend from the child death notifications received by the Office, with increased child death notifications concerning apparent suicide in the 6 to 12 year old age group, particularly involving children with a history of child protection involvement with the Department of Communities.

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.<sup>1</sup>

Accordingly, after reviewing information arising from these child death reviews, information provided by agencies 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.

The Ombudsman's second investigation into child deaths by suicide, *Preventing suicide by children and young people 2020*, 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.

---

<sup>1</sup> 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.



*Preventing suicide by children and young people 2020* 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 considered 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.

The report of the findings and recommendations arising from the Ombudsman's investigation, titled *Preventing suicide by children and young people 2020 (the Report)*, was tabled in the Parliament of Western Australia on 24 September 2020. The Report is available at [www.ombudsman.wa.gov.au/suicidebychildrenandyoungpeoplereport2020](http://www.ombudsman.wa.gov.au/suicidebychildrenandyoungpeoplereport2020).

## **1.5 A report on the steps taken to give effect to the recommendations arising from the Report**

### **1.5.1 Objectives**

The Report made seven recommendations about ways to prevent or reduce suicide by children and young people.

The objectives of this report were to consider (in accordance with the Act):

- 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.

This report also considered 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.

### **1.5.2 Methodology**

On 21 May 2021, the Ombudsman wrote to the Mental Health Commissioner, the Director General of the Department of Communities, the Director General of the Department of Health, and the Director General of the Department of Education requesting a report on the steps that have been taken, or were proposed to be taken, to give effect to the recommendations of the Report.

Additionally, the Office:

- obtained further information from the relevant State government departments and authorities, in order to clarify or validate information provided in their reports to the Ombudsman;
- collected additional information relevant to suicide by young people in Western Australia to inform the consideration of whether the steps taken by relevant State government departments and authorities seem appropriate;
- reviewed relevant current national and international literature regarding suicide by children and young people and the associated risk factors;
- developed a preliminary view and provided it to relevant State government departments and authorities for their consideration and response;
- developed a final report on whether steps have been taken to give effect to the recommendations.

## 2 Steps taken to give effect to the recommendations

### 2.1 Recommendation 1

**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.

Tragically, as identified in the Report, 11 children aged 10 to 13 years died by suicide in Western Australia during the 2020 Investigation period. As discussed in Chapter 3 of Volume 3 of the Report, 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';<sup>2</sup> and
- by 8 years of age, children have a thorough understanding of suicide and are capable of carrying it out.<sup>3</sup>

---

<sup>2</sup> 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.

<sup>3</sup> 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](https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf)>.

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'.<sup>4</sup>

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.<sup>5</sup>

In children, suicide attempts may be more likely to be impulsive, arising from feelings of 'sadness, confusion, anger, or problems with attention and hyperactivity'<sup>6</sup> or a 'wish to end their emotional pain.'<sup>7</sup>

A 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.'<sup>8</sup>

Suicide attempts in childhood are also a major predictor of future suicide in later adolescence and adulthood,<sup>9</sup> with children who attempt suicide being 'up to six times more likely to attempt suicide again in adolescence.'<sup>10</sup>

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

---

<sup>4</sup> 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.

<sup>5</sup> 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.

<sup>6</sup> 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](https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx)>.

<sup>7</sup> 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](https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf)>.

<sup>8</sup> 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.

<sup>9</sup> 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](https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf)>.

<sup>10</sup> 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](https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf)>.

(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 2:

**Figure 2: 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

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, including Orygen’s *Raising the Bar for Youth Suicide Prevention* report, suggests that a youth specific strategic response to suicide prevention is required for a number of reasons, including that:

- young people are at increased susceptibility to the onset of mental health issues due to the age and stage of their development and the ‘well-documented elevated risk of suicide among those ... young people with serious and complex experiences of mental ill-health, for example affective disorders, personality disorders and psychosis’;<sup>11</sup>
- high rates of self-harm in young people ‘should act as an early indication for service providers and policy makers that many young people are distressed and crying out for help’;<sup>12</sup> and

<sup>11</sup> Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

<sup>12</sup> Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

- data analysis 'has shown that a youth suicide is more likely to be part of a cluster than an adult suicide ... [suggesting] that responding to suicide among young people requires a different approach than for other age groups.'<sup>13</sup>

Children and young people seeking help for self-harm and suicidal behaviours also face unique barriers as compared with adults, including:

- Barriers experienced by children and young people included feelings of embarrassment and guilt, and fear of the response from parents and other sources of help.
- Barriers associated with parents and carers included limited awareness of available support services and worries about cost of services/treatments.
- Barriers as a result of system constraints included lack of appropriate and culturally sensitive support services and limited capacity of support services where there are waiting lists and motivation to seek support may have decreased by the time an appointment is available.<sup>14</sup>

The research literature also highlighted the importance of regular evaluation in working towards a comprehensive response to suicide prevention, including 'seek[ing] out young people's views to a) ensure youth-related outcomes are collected and b) determine the program's acceptability and appropriateness.'<sup>15</sup>

For these reasons, the Ombudsman made Recommendation 1.

The Office requested that the Mental Health Commission inform the Office of the steps taken to give effect to the recommendation. In response, the Mental Health Commission provided the following information:

The Western Australian Suicide Prevention Framework 2021-2025 (The Framework) was released October 2020, it provides a coordinated approach to address suicide prevention activity under the streams of prevention/early intervention, support/aftercare, postvention and Aboriginal people.

The Framework was developed following extensive consultation and engagement with key stakeholders, and utilizing findings from ongoing evaluation, emerging evidence and research.

The Framework has received \$32.3 million funding to address some of the suicide prevention initiatives to support the implementation of the Framework across the state.

The Suicide Prevention Framework 2025 aims to promote a whole-of-state approach to suicide prevention in Western Australia, and to reduce duplication of services, lessening confusion in the suicide prevention space for consumers, and providing the support and help our communities need to prevent suicide.

---

<sup>13</sup> Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016, p. 7.

<sup>14</sup> Australian Human Rights Commission, *Intentional self-harm and suicidal behaviour in children*, AHRC, Sydney, June 2018, viewed 10 September 2018 <<https://www.humanrights.gov.au/our-work/childrens-rights/projects/intentional-self-harm-and-suicidal-behaviour-children>>.

<sup>15</sup> Robinson J et al, *Raising the bar for youth suicide prevention*, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, 2016.

The Suicide Prevention Framework 2025 includes prevention and early intervention as a key priority area and identifies children and young people as being vulnerable to suicide and suicidal behaviour.

The MHC launched the Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 (YPPA) to support and respond to the mental health and AOD needs of young people aged 12-24 years.

Development of The Framework and the YPPA included consultation with young people, their families and carers and the Youth Affairs Council of WA.

A framework for children aged 0-11 years will be developed in the near future.

**Having carefully considered the information provided by the Mental Health Commission, I am of the view that steps have been taken and are proposed to be taken to give effect to Recommendation 1.**

This page has been intentionally left blank.



## 2.2 Recommendation 2

**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.

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.<sup>16</sup>

However, as observed in the *Bringing them home* report, the British ‘invasion’<sup>17</sup> of Australia brought very rapid changes to Aboriginal and Torres Strait Islander societies and widespread forcible removal of Aboriginal children from their families. 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.<sup>18</sup>

As noted in the Report, suicide by Aboriginal people was extremely rare and ‘almost unheard of prior to the 1960s.’<sup>19</sup> Beginning in the 1980s, the number of Aboriginal people who died by suicide began to increase, a trend that has continued over time.

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:

---

<sup>16</sup> 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>>.

<sup>17</sup> 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.

<sup>18</sup> 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](https://www.healingfoundation.org.au/app/uploads/2018/09/Stolen_Generation_Demographic_Report_Factsheet_Jun2018_V7.pdf)>, p. 4.

<sup>19</sup> 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.

- 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;<sup>20</sup>
- high levels of stress and isolation arising from their roles as carers of parents and siblings with mental illness or disability;<sup>21</sup> and
- racism, which has been shown to exacerbate mental health issues, negate the protective effects of parenting and family function, limit the capacity of parents to promote child development and access culturally appropriate supports for their family, and is associated with poor physical and mental health and negative social and emotional wellbeing of children (including anxiety, depression, low self-esteem, suicide and self-harm).<sup>22</sup>

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 achieve social and economic equity for their communities through self-determination and culturally informed solutions. The research literature also identified 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.<sup>23</sup>

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 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

---

<sup>20</sup> ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <[http://www.sis.uwa.edu.au/\\_\\_data/assets/pdf\\_file/0010/2790937/Fact-Sheet-No.-5.pdf](http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf)>.

<sup>21</sup> ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <[http://www.sis.uwa.edu.au/\\_\\_data/assets/pdf\\_file/0010/2790937/Fact-Sheet-No.-5.pdf](http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf)>.

<sup>22</sup> ATSISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, viewed 23 September 2018, <[http://www.sis.uwa.edu.au/\\_\\_data/assets/pdf\\_file/0010/2790937/Fact-Sheet-No.-5.pdf](http://www.sis.uwa.edu.au/__data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf)>.

<sup>23</sup> 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>>.

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.<sup>24</sup>

Forty three of the 115 children and young people were recorded as identifying as Aboriginal or Torres Strait Islander (37 per cent). For these reasons, the Ombudsman made Recommendation 2.

The Office requested that the Mental Health Commission inform the Office of the steps taken to give effect to the recommendation. In response, the Mental Health Commission provided the following information:

The Framework [the Western Australian Suicide Prevention Framework 2021-2025] received an additional \$9.8 million for the development and implementation of regional Aboriginal Suicide Prevention Plans across Western Australia.

Each regional plan prioritized Aboriginal-led and locally endorsed initiatives that accommodate a culturally informed social and emotional wellbeing approach to suicide prevention and includes initiatives targeting young people.

All regional [Aboriginal Suicide Prevention] plans were completed by June 2021. Tender for the implementation was released February 2021 [and] closed April 2021. Successful organisations were appointed June 2021.

**Having carefully considered the information provided by the Mental Health Commission, I am of the view that steps have been taken and are proposed to be taken to give effect to Recommendation 2.**

---

<sup>24</sup> ATISPEP, *Fact Sheet 5: Examining the risk factors for suicidal behaviour of Aboriginal and Torres Strait Islander children*, p. 2.

This page has intentionally been left blank.

## 2.3 Recommendation 3

**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.

The Report noted that ATSISEPEP’s *Real Time Suicide Data: A Discussion Paper* identified that the ‘variable quality of Aboriginal and Torres Strait Islander identification at the State and national levels, resulting in an unexpected under-reporting’<sup>25</sup> of Aboriginal and Torres Strait Islander people who died by suicide. Accordingly, 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 1: 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:

<sup>25</sup> 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](https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf)>, p. 2.

- 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,<sup>26</sup> and understanding the community's 'language, traditions and customs and family and community obligations'<sup>27</sup> 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.

For these reasons, the Ombudsman made Recommendation 3.

The Office requested that the Mental Health Commission inform the Office of the steps taken to give effect to the recommendation. In response, the Mental Health Commission provided the following information:

The Mental Health Commission has requested a meeting with key representatives from the Department of Health, Department of Communities and Department of Education to discuss a strategic approach to progress Recommendation 3.

The Office requested that the Department of Health inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Health provided the following information:

As you are aware, the four Preventing Suicide by Children and Young People recommendations directed to the Department of Health (3,4,5 and 7) require collaboration with other agencies.

The Mental Health Commission will be convening a meeting to enable the agencies to consider how to progress the recommendations.

In relation to Recommendation 3:

- Health service staff receive training on how to appropriately obtain and record the Aboriginal status of all patients receiving care in the WA health system and this is a mandatory data item for collection as outlined in the Patient Activity Data Policy.
- Aboriginal status is collected widely across the WA health system, with collections containing Aboriginal status including the Hospital Morbidity Data Collection (inpatients), the Non-Admitted Data Collection, Midwives Notification System, Emergency Department Data Collection and Mental Health Data Collection. In most collections, the code-list either matches

---

<sup>26</sup> 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](https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf)>, p. 3.

<sup>27</sup> 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.

or can be mapped to the National Standard for Indigenous Status. Additional collections outside of the Department's Information and System Performance Directorate team (e.g. WA Notifiable Infectious Diseases Database) also collect Aboriginal status.

- Utilising a validated algorithm, the Department's Data Linkage System can generate a Derived Aboriginal and Torres Strait Islander Status Flag for any individual with at least one record in a number of WA government administrative data sets where Aboriginal and Torres Strait Islander status is recorded.
- The Department is developing or has established Memorandums of Understanding and Data Sharing agreements with the MHC, Department of Education and Department of Communities. Which includes the sharing of Aboriginal status information when required. Recent work with the Department of Premier and Cabinet on data sharing across agencies relating to COVID-19 included aggregate information on Aboriginal status.
- Health information can be shared, when its use is consistent with the legal purposes outlined in the *Health Services Act 2016*. Such purposes would include improving health outcomes for children and young people.

The Office requested that the Department of Education inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Education provided the following information:

The Department will collaborate with named agencies to plan and operationalize the recommendation. The Mental Health Commissioner is in the process of seeking Directors' General nominations for senior officers to progress recommendations.

The Department's Aboriginal Cultural Standards Framework continues to guide the Department's work to develop mutually respectful relationships with Aboriginal students, families and communities to strengthen the wellbeing of Aboriginal children and young people. The Department will ensure that all staff continue to have access to ongoing professional learning to support the provision of culturally responsive approaches when working with Aboriginal children and young people, their families and communities.

The Department continues to provide professional learning, advice and guidance to school staff to embed whole-school culturally responsive practices and approaches, and to strengthen their understanding of how to use the Aboriginal Cultural Standards framework in reflection and planning. The School Psychology Graduate Induction Program includes a full day program on the Aboriginal Cultural Standards Framework and perspectives on working with Aboriginal clients and communities to inform psychological practice. In 2021, 38 graduates attended the professional learning. A Lead School Psychologist interest group has been established for the purpose of identifying opportunities to strengthen cultural responsiveness within the School Psychology Service. Aboriginal concepts of mental health and social and emotional wellbeing will inform the research and professional learning programs under development.

The Department will draw on the leadership, knowledge and expertise of Aboriginal and Torres Strait Islander people to identify culturally responsive and safe approaches to the collection of data regarding a person's cultural identity in situations where there are concerns about a child or young person's self-harming

or suicidal behaviour. The Department will establish an Aboriginal advisory group to inform support for the mental health and wellbeing of Aboriginal and Torres Strait Islander students in Western Australian public schools. The Chief Psychologist is consulting with relevant professionals to inform the development of a proposed model.

The *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury* (Guidelines) will be further updated to consider cultural safety and wellbeing of Aboriginal children and young people. Advice and guidance will be sought from Aboriginal psychologists, academics and/or mental health professionals to inform future updates. The updated Guidelines, published January 2021, included a strengthening of the section regarding Aboriginal and Torres Strait Islander students to reflect cultural safety and healing. This section also notes the importance of exploring cultural identity in a safe way when undertaking a suicide risk assessment. The Guidelines continue to be strengthened with regard to the cultural safety and wellbeing of Aboriginal children and young people.

The School Psychology Service Professional Practice Guidelines: *Suicidal Behaviour and NSSI* will be updated to further consider cultural safety and wellbeing of Aboriginal children and young people. Advice and guidance will be sought from Aboriginal psychologists, academics and/or mental health professionals to inform future updates.

The Office requested that the Department of Communities inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Communities provided the following information:

Communities is undertaking a scoping of work required to establish an internal implementation plan for improvements to practice and operations in relation to at-risk youth. Findings from the Ombudsman Own Motion Investigation will also be used to inform the strategies for the implementation of the four recommendations delivered to Communities. Further detail of the work to implement the necessary improvements will be provided to your office in October 2021.

**Having carefully considered the information provided by the Mental Health Commission, Department of Health, Department of Education and Department of Communities, I am of the view that steps are proposed to be taken to give effect to Recommendation 3.**



## 2.4 Recommendation 4

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

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

The Office 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.

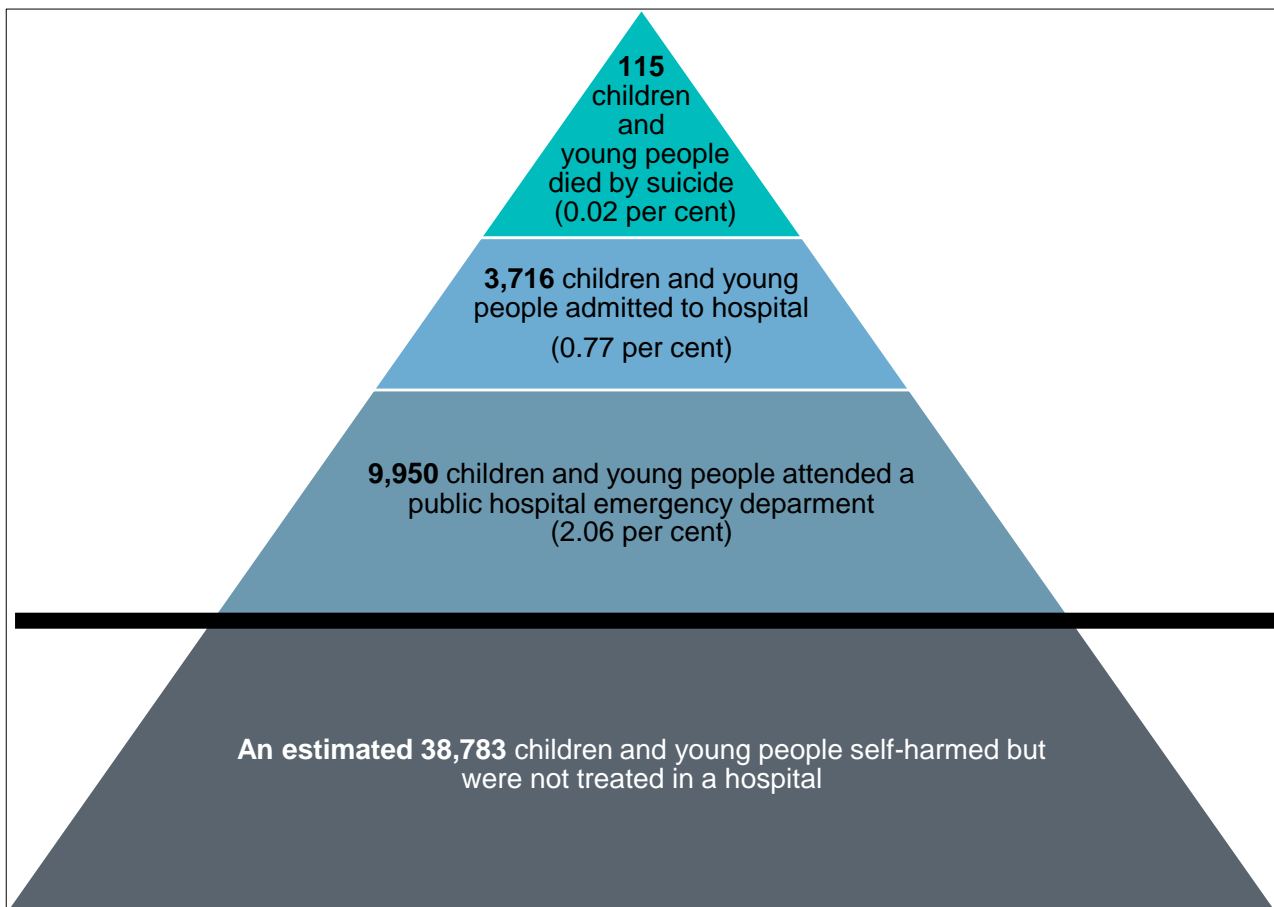
The Report also identified and drew upon research literature conceptualising deaths by suicide as the highly visible tip of an 'iceberg' model of suicidal and self-harming behaviour which 'conveys the hierarchical yet dynamic nature of self-harm'<sup>28</sup> in the community.

Accordingly, given the 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.

---

<sup>28</sup> 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.

**Figure 3: 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 identified 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.’ ATISISPEP’s *Real Time Suicide Data: A Discussion Paper* poignantly highlighted 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.’<sup>29</sup>

The Office noted 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.’<sup>30</sup>

<sup>29</sup> 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](https://www.atsispep.sis.uwa.edu.au/_data/assets/pdf_file/0009/2947482/Real-Time-Suicide-Data.pdf)>, p. 8.

<sup>30</sup> 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, for the above reasons, the Ombudsman made Recommendation 4.

The Office requested that the Mental Health Commission inform the Office of the steps taken to give effect to the recommendation. In response, the Mental Health Commission provided the following information:

The Mental Health Commission has requested a meeting with key representatives from the Department of Health, Department of Communities and Department of Education to discuss a strategic approach to progress Recommendation 4.

The YPPA [Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025] prioritises the development of a linked data collection system recording the prevalence and characteristics associated with self-harm by children and young people.

An immediate action to achieve this is to:

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

The Office requested that the Department of Health inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Health provided the following information:

As you are aware, the four Preventing Suicide by Children and Young People recommendations directed to the Department of Health (3, 4, 5 and 7) require collaboration with other agencies.

The Mental Health Commission will be convening a meeting to enable the agencies to consider how to progress the recommendations.

**Having carefully considered the information provided by the Mental Health Commission and the Department of Health, I am of the view that steps have been taken and are proposed to be taken to give effect to Recommendation 4.**

This page has been intentionally been left blank.

## 2.5 Recommendation 5

### Recommendation 5:

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

As identified in Chapters 3.5.8 and 5.1 of Volume 3 of the Report, LGBTQI+ communities across the world are a vulnerable group with higher rates of suicide.<sup>31</sup>

A 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)'.<sup>32</sup> 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 Western Australian 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'.<sup>33</sup>

The Office identified a significant gap in the evidence base 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.

The Report identified that, 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 ...

---

<sup>31</sup> World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 37.

<sup>32</sup> Skerett DM, Kölves 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.

<sup>33</sup> 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.

Departments and agencies should ensure when they collect sex and/or gender information they use the correct terminology for the information they are seeking.<sup>34</sup>

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 2:

**Table 2: Summary of data recorded relating to sex and gender, by State government department**

	Department of Health	Department of Communities
<b>Does the department or authority record sex or gender?</b>	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
<b>Is sex or gender data captured in a non-binary format?</b>	Sex data is captured in a non-binary format, as: <ul style="list-style-type: none"> <li>• male, female or indeterminate in TOPAS, HCARE and webPAS;<sup>35</sup> and</li> <li>• male, female, 'intersex or indeterminate, or not stated/inadequately described' in the Emergency Department Data Collection.<sup>36</sup></li> </ul>	No: Binary
<b>Are there any relevant legislative or policy considerations relating to the recording of data on sex and gender?</b>	Binding Information Management Policy Framework issued by the Director General under section 26 of the <i>Health Services Act 2016</i> <sup>37</sup>	None publicly available

Source: Ombudsman Western Australia

In particular, the Office noted that the *Victorian Family Violence Data Collection Framework* (in its guidelines for collecting data relating to family violence experienced by LGBTIQ+ communities) stated 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 observed 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.'<sup>38</sup>

<sup>34</sup> 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.

<sup>35</sup> Department of Health, *Hospital Morbidity Data System: HMDS Reference Manual*, Government of Western Australia, Perth, 2015, pp. 159-160.

<sup>36</sup> Department of Health, *Emergency Department Data Collection Data Dictionary*, Government of Western Australia, Perth, 2007, pp. 104-105.

<sup>37</sup> Department of Health, *Information Management, Version 10*, 18 October 2018.

<sup>38</sup> Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

Further, the *Victorian Family Violence Data Collection Framework* highlighted 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.'<sup>39</sup>

Under the guidelines provided in the Framework, sexual orientation data should only be collected in circumstances where:

- agencies are 'aware of and understand the needs of diverse LGBTI communities so that they may collect information appropriately, and provide an appropriate response';<sup>40</sup>
- people are willing to disclose;<sup>41</sup>
- the information can be collected and stored sensitivity, bearing in mind privacy implications and relevant legislative requirements;<sup>42</sup> and
- there is a clear link to 'a direct service response or referral to an appropriate service'.<sup>43</sup>

Accordingly, the Ombudsman found that there was 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 made Recommendation 5.

The Office requested that the Department of Health inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Health provided the following information:

In relation to Recommendation 5:

- The WA Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy 2019-2024 sets out priorities for the WA health system to achieve optimal health and wellbeing outcomes for LGBTI populations. Priority 3 under this strategy specifically addresses strengthening the data collection, evaluation and monitoring of the health and wellbeing needs of WA LGBTI populations.
- The Department's Information and Performance Governance Unit is actively working on the implementation of the collection of gender (including a non-binary form) in addition to sex across the WA health system. As these are core demographics fields, the changes required to accommodate gender diversity need to be managed across several vendor managed information systems and downstream data collections, together with changes to hospital business rules and alignment with

---

<sup>39</sup> Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

<sup>40</sup> Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 54.

<sup>41</sup> Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 54.

<sup>42</sup> Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 56.

<sup>43</sup> Department of Premier and Cabinet, *Victorian Family Violence Data Collection Framework*, Victorian Government, Melbourne, December 2019, p 57.

emerging national health definitions. As such, this is a multiyear project within the Information Management Reform program.

- Other changes such as the recording of pronouns and preferred names will be investigated together with the implementation of the collection of gender.
- The recording of information about a child or young person's sexuality required a targeted rather than a system-wide approach and is under further consideration.

The Office requested that the Department of Communities inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Communities provided the following information:

Communities is undertaking a scoping of work required to establish an internal implementation plan for improvements to practice and operations in relation to at-risk youth. Findings from the Ombudsman Own Motion Investigation will also be used to inform the strategies for the implementation of the four recommendations delivered to Communities. Further detail of the work to implement the necessary improvements will be provided to your office in October 2021.

**Having carefully considered the information provided by the Department of Health and the Department of Communities, I am of the view that steps have been taken and are proposed to be taken to give effect to Recommendation 5.**



## 2.6 Recommendation 6

**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.

The Report noted research literature identifying that children and young people who experience cumulative harm and complex trauma arising from child abuse or neglect are at higher risk of suicide and other mental health issues.<sup>44</sup> Children and young people in out of home care are recognised as 'particularly vulnerable and often experience significant risk factors and unmet need'.<sup>45</sup>

In addition, the Report observed recent research literature highlighting that repeated adverse family experiences (also known as 'adverse childhood experiences' or 'ACEs'), such as chronic abuse and/or neglect in childhood, increased 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.'<sup>46</sup>

The research literature noted 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', such as 'less obvious' indicators of neglect in older children, an increased prevalence 'self-harm or offending behaviour

---

<sup>44</sup> World Health Organization, *Preventing suicide: a global imperative*, World Health Organization, Luxembourg, 2014, p. 36.; 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.

<sup>45</sup> 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.

<sup>46</sup> 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.

...exposure to child sexual exploitation ... or violence' amongst this cohort, and the idea that older children are 'choosing a lifestyle' or 'resilient' and 'do not need help'.<sup>47</sup>

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 noted 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;<sup>48</sup> 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.<sup>49</sup>

Of the 50 children and young people in Group 1 in the 2020 Investigation, records indicated that 39 (78 per cent) allegedly experienced more than one form of child abuse or neglect, and therefore are likely to have suffered cumulative harm.

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).

The Report 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, 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).

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'.

---

<sup>47</sup> 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](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722740/Older_child_en_neglect_FINAL_060718.pdf)> .

<sup>48</sup> 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.

<sup>49</sup> 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>>.

The Office also found that 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 of the Report, Aboriginal children and young people continued 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 the Department of Communities, and found that the greatest number of interactions, initial inquiries and safety and wellbeing assessments occurred between the ages of 12 to 14.

At the time of the Report's publication, the Department of Communities' *Casework Practice Manual* stated that:

If contacted about a child or young person's suicidal thoughts or behaviours, child protection workers should:

- gather information about the extent of the concerns about the child or young person
- review any chronology of past incidents of harmful events or experiences, reports of abuse or neglect
- where possible meet with the child or young person to discuss the concerns about them, (other professionals known to the child or young person may also attend where appropriate)
- contact other individuals to gather information about the extent of the child or young person's suicide concerns
- if the child or young person resides in another district, organise for the appropriate district office to respond, and

- ask the contacting individual if they require any follow-up support, and refer them to an appropriate service.<sup>50</sup>

The Office analysed the Department of Communities' response to reported 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. 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. However, 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 made Recommendation 6.

The Office requested that the Department of Communities inform the Office of the progress towards completing the report required in order to give effect to this recommendation. In response, the Department of Communities provided the following information:

In 2019, the Department of Communities (Communities) undertook a thematic analysis of 22 finalised child death reviews finalised since 1 July to:

- collate information about vulnerable cohorts within the community including common risk factors;
- identify common practice issues related to Communities administration of the *Children and Community Services Act 2004* and related policies and procedures;
- identify systemic barriers to child safety; and
- draw connections between the findings of child death reviews and other oversight agency investigations.

Young people age 10 to 18 years were identified through the thematic analysis as an emerging at risk cohort.

Following from the thematic analysis, Communities has undertaken a further cohort review of at-risk youth. The following themes emerged from the review:

1. Improving practice guidance about the Department's role and responsibilities in circumstances where a child or young person is referred to the Department in relation to concerns about their wellbeing. This includes recognising wellbeing concerns as indicators of abuse and neglect, assessing harm arising from cumulative abuse and understanding when observed strengths, resilience or other protective factors may translate into safety in relation to the identified abuse/danger.
2. Improving interagency communication and collaboration to better respond to complex intersecting issues in families where there is a young person at risk of suicide or other type of harm including as a result of substance abuse; and
3. Addressing practice and systemic issues through dedicated strategic policy and frameworks such as the At-Risk Youth Strategy.

---

<sup>50</sup> Department of Communities, Government of Western Australia, *Casework Practice Manual: 1.4.5 Suicide and self-harm*, 3 July 2018, viewed 5 May 2019, <<https://manuals.dcp.wa.gov.au/CPM/SitePages/Procedure.aspx?ProcedureId=146>>.

Common risk factors across both reviews included exposure to family violence and parental substance use. Other risk factors for this cohort included parental mental illness, parents who experienced abuse as children, homelessness or housing instability and Aboriginality. The identification of these risk factors will assist Communities to target implementation strategies in the development of the internal implementation plan for improving responses for at-risk youth.

Communities is undertaking a scoping of work required to establish an internal implementation plan for improvements to practice and operations in relation to at-risk youth. Findings from the Ombudsman Own Motion Investigation will also be used to inform the strategies for the implementation of the four recommendations delivered to Communities. Further detail of the work to implement the necessary improvements will be provided to your office in October 2021.

**Having carefully considered the information provided by the Department of Communities, I am of the view that steps have been taken and are proposed to be taken to give effect to Recommendation 6. Further, the Office will carefully consider the report from the Department of Communities as set out in the recommendation upon receipt and publish an update on the steps taken to give effect to Recommendation 6 in the Ombudsman's 2021-22 Annual Report.**

This page has intentionally been left blank.

## 2.7 Recommendation 7

**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.

The Report identified an important theme arising from child death reviews and related own motion investigations of the Office regarding the need for State government departments and authorities to:

- share information to facilitate the effective identification of young people at risk of suicide; and
- make 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 further identified that challenging behaviours exhibited by children and young people experiencing cumulative harm are often not understood in the context of trauma.<sup>51</sup>

The Report noted that 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'<sup>52</sup> or have parents experiencing mental health, drug or alcohol issues.<sup>53</sup> Others have introduced long-term early intervention initiatives to reduce rates of developmentally vulnerable children and young people in areas of socio-economic disadvantage.<sup>54</sup>

---

<sup>51</sup> 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](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722740/Older_childr_en_neglect_FINAL_060718.pdf)> pp. 8-10.

<sup>52</sup> 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/>>.

<sup>53</sup> 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>>.

<sup>54</sup> 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 identified that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help',<sup>55</sup> and agencies face challenges in providing services to these young people.<sup>56</sup>

The Report noted that one example of a case management approach for at-risk young people in Western Australia was the Young People with Exceptionally Complex Needs program (**the YPECN program**) which had been expanded to support 14 young people (from a commencement capacity of 12 young people).

The Report also noted that 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.'<sup>57</sup> 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.'<sup>58</sup>

However, despite these encouraging developments, the Western Australian research literature had 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 ... to ensure effective communication between multiple agencies working on the same case.'<sup>59</sup>

As noted in the Report, the Office also found that 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) and had contact with multiple State government agencies, particularly the Department of Communities, Department of Education and the Department of Health. Many of these children and young people were characterised in agency records as 'hard to help'.

Accordingly, for the above reasons, the Ombudsman made Recommendation 7.

---

<sup>55</sup> 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.

<sup>56</sup> 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.

<sup>57</sup> 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.

<sup>58</sup> 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.

<sup>59</sup> 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.



The Office requested that the Mental Health Commission inform the Office of the steps taken to give effect to the recommendation. In response, the Mental Health Commission provided the following information:

The YPPA [Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025] and its implementation contribute to addressing recommendation 7. The importance of cross-sector collaboration to respond to, and meet the complex needs of young people with mental health, AOD and other related and impacting issues is the foundation of the YPPA.

The MHC is leading the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA (the ICA Taskforce). Work is well underway with the ICA Taskforce having met four times since its formation in March 2021. An Interagency Expert Advisory Group has been formed to support the ICA Taskforce. Membership includes representatives from agencies such as Department of Communities, Department of Education and various health service providers (HSPs). An emerging directions paper will be delivered by 31 July 2021. The final report will include a costed implementation plan and will be delivered by 30 November 2021.

The Mental Health Commission has requested a meeting with key representatives from the Department of Health, Department of Communities and Department of Education to discuss a strategic approach to progress Recommendation 7.

The Office requested that the Department of Health inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Health provided the following information:

As you are aware, the four Preventing Suicide by Children and Young People recommendations directed to the Department of Health (3, 4, 5 and 7) require collaboration with other agencies.

The Mental Health Commission will be convening a meeting to enable the agencies to consider how to progress the recommendations.

The Office requested that the Department of Education inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Education provided the following information:

The Department [will] collaborate with other agencies in the development and implementation of the interagency model. Through cross agency meetings, the Department will advocate for the model to be consistent with and informed by:

- the *National Agreement on Closing the Gap*
- the State's Closing the Gap Implementation plan; and
- the Department's commitments outlined in the *Commitment to Aboriginal Youth Wellbeing*.

The Department will draw upon Aboriginal lead research to inform the evidence-based interagency model. The Mental Health Commissioner is in the process of seeking Directors' General nominations for a senior officers working group to progress implementation of the recommendations. Through the senior officers working group, the Department will advocate for student voice to be considered as part of any consultation process.

Links to the interagency model will be referred to in the relevant Department of Education policies and programs. Relevant Department policies will be reviewed to consider referencing the interagency model. This will be undertaken once the interagency model is developed.

Consideration will be given to the role of the School Chaplaincy Program in the interagency model, including the Pastoral Critical Incident Response team that provides emergency support to local school communities.

Establishment of mechanisms identifying children and young people at high risk of disengagement at school. The Department will identify data sets that may assist in the development of the interagency model. Once developed, the interagency model will be incorporated into operational guidelines for students with complex needs.

The Department of Education has expanded the range of services it provides to students experiencing circumstances of adversity through the development and implementation of its Full Service School, which:

Provide[s] a service to young people whose risk factors include:

- homelessness
- teenage pregnancy
- disengagement from education and social and community services.

The Full Service School (FSS) servicing the Armadale, Byford and Kelmscott areas works collaboratively with other agencies to strengthen the links between schools and their communities. They provide a range of youth and family support services for young people who are pregnant or parenting, and/or vulnerable to homelessness or family and domestic violence. The Department has developed online information and guidance for schools to identify, respond and support students affected or at risk of homelessness. Once developed, the interagency model's alignment with Full Service Schools and Homeless[ness] resources will be considered.

The School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury will be updated to consider strategies to support children and young people with complex needs, including those experiencing multiple risk factors associated with suicide. An update to the Guidelines was published January 2021. Noting that refinements will continue as required.

The School Psychology Service Professional Practice Guidelines: *Suicidal Behaviour and NSSI* will be updated to consider strategies to support children and young people with complex needs, including those experiencing multiple risk factors associated with suicide. Advice and guidance will be sought from relevant stakeholders to inform future updates.

The Mental Health Commission will be convening a meeting to enable the agencies to consider how to progress the recommendations.

The Office requested that the Department of Communities inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Communities provided the following information:

Communities is undertaking a scoping of work required to establish an internal implementation plan for improvements to practice and operations in relation to at-risk youth. Findings from the Ombudsman Own Motion Investigation will also be used to inform the strategies for the implementation of the four recommendations delivered to Communities. Further detail of the work to implement the necessary improvements will be provided to your office in October 2021.

**Having carefully considered the information provided by the Mental Health Commission, Department of Health, Department of Education and Department of Communities, I am of the view that steps have been taken and are proposed to be taken to give effect to Recommendation 7.**

This page has been intentionally left blank.

# Major Investigations and Reports

Title	Date
<u><i>An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley</i></u>	<b>July 2021</b>
<u><i>Preventing suicide by children and young people 2020</i></u>	<b>September 2020</b>
<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>	<b>November 2018</b>
<u><i>Investigation into ways to prevent or reduce deaths of children by drowning</i></u>	<b>November 2017</b>
<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>	<b>November 2016</b>
<u><i>Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities</i></u>	<b>November 2015</b>
<u><i>Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people</i></u>	<b>April 2014</b>
<u><i>Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths</i></u>	<b>November 2012</b>
<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>	<b>November 2011</b>
<u><i>The Management of Personal Information - good practice and opportunities for improvement</i></u>	<b>March 2011</b>
<u><i>2009-10 Survey of Complaint Handling Practices in the Western Australian State and Local Government Sectors</i></u>	<b>June 2010</b>

## **Ombudsman Western Australia**

Level 2, 469 Wellington Street Perth WA 6000

PO Box Z5386 St Georges Terrace Perth WA 6831

Tel 08 9220 7555 • Freecall (free from landlines) 1800 117 000 •

Email [mail@ombudsman.wa.gov.au](mailto:mail@ombudsman.wa.gov.au) • Website [www.ombudsman.wa.gov.au](http://www.ombudsman.wa.gov.au)