



Preventing suicide by children and young people 2020

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

Ombudsman Western Australia
Serving Parliament – Serving Western Australians

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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)

Facsimile:(08) 9220 7500

Email: mail@ombudsman.wa.gov.au

Web: www.ombudsman.wa.gov.au

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

CONTENT WARNING

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

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About the report

1.1 The Western Australian Ombudsman

1.1.1 The role of the Ombudsman

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

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

- receives, investigate and resolves complaints about State government agencies, local governments and universities;
- reviews certain child deaths and family and domestic violence fatalities;
- undertakes own motion investigations; and
- undertakes a range of additional functions, including statutory inspection and monitoring functions.

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:

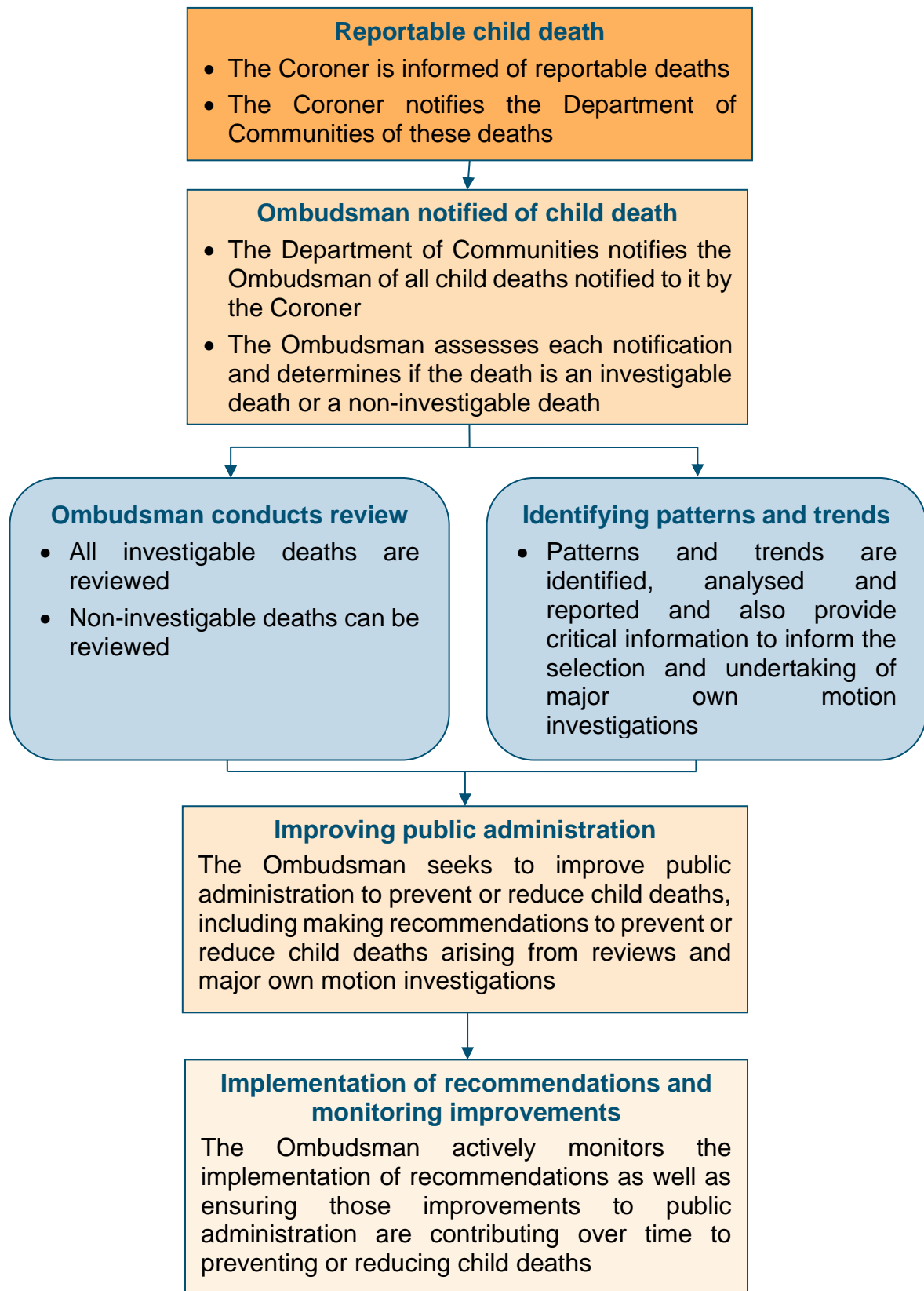
- (a) to review the circumstances in which and why the deaths occurred;
- (b) to identify any patterns or trends in relation to the deaths;
- (c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

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 Giving effect to recommendations of the Ombudsman

1.3.1 Monitoring the implementation of recommendations

Each recommendation arising from an own motion investigation is actively monitored by the Office to ensure its implementation and effectiveness, in accordance with sections 25(4) and (5) of the Act, 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.

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

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:

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

For the above reasons, the Ombudsman decided to undertake a major own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by young people (**the 2014 Investigation**). 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

1.3.3 A report on giving effect to the recommendations arising from the 2014 Investigation

1.3.3.1 Objectives

The 2014 Investigation made 22 recommendations about ways to prevent or reduce suicide by 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.

1.3.3.2 Methodology

On 16 December 2016, the Ombudsman wrote to the (then) Mental Health Commissioner, the (then) Director General of the Department for Child Protection and Family Support, the Director General of the Department of Health, and the (then) 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 2014 Investigation.

Additionally, the Office:

- met with the relevant State government departments and authorities to obtain further information, 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; and
- reviewed relevant current national and international literature regarding suicide by children and young people and the associated risk factors.

After reviewing the information provided by these agencies, and information arising from the reviews of the lives of children and young people who died by suicide following the 2014 Investigation along with 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.

On 13 April 2017, the Ombudsman wrote to the (then) Mental Health Commissioner, the (then) Director General of the Department for Child Protection and Family Support, the Director General of the Department of Health, the (then) Director General of the Department of Education, and the Chief Psychiatrist of Western Australia, to inform these departments and authorities of his intention to commence an own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people. The Ombudsman also informed these agencies that this investigation would be reported to the Western Australian Parliament concurrently with the report on giving effect to the recommendations arising from the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people 2014*.

1.3.4 The Ombudsman's Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people (the 2020 Investigation)

1.3.4.1 Objectives

The objectives of the 2020 Investigation were 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.

1.3.4.2 Methodology

To undertake the own motion investigation, the Office:

- conducted a review of relevant national and international literature regarding suicide by children and young people (which is referred to as **the research literature** throughout this report);
- consulted with government and non-government organisations;

- collected data from State government departments and authorities about each of the 79 children and young people who died by suicide during the 2020 Investigation period (**the 79 children and young people**);
- analysed the data relating to the 79 children and young people using qualitative and quantitative techniques to develop draft findings;
- consulted relevant stakeholders regarding the results of our analysis as well as engaging external professionals with expertise regarding suicide by children and young people to critically comment and review the data collection, analysis and draft findings;
- developed a preliminary view and provided it to relevant State government departments and authorities for their consideration and response; and
- developed a final view including findings and recommendations.

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2 Steps taken to give effect to the recommendations

2.1 Recommendation 1

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

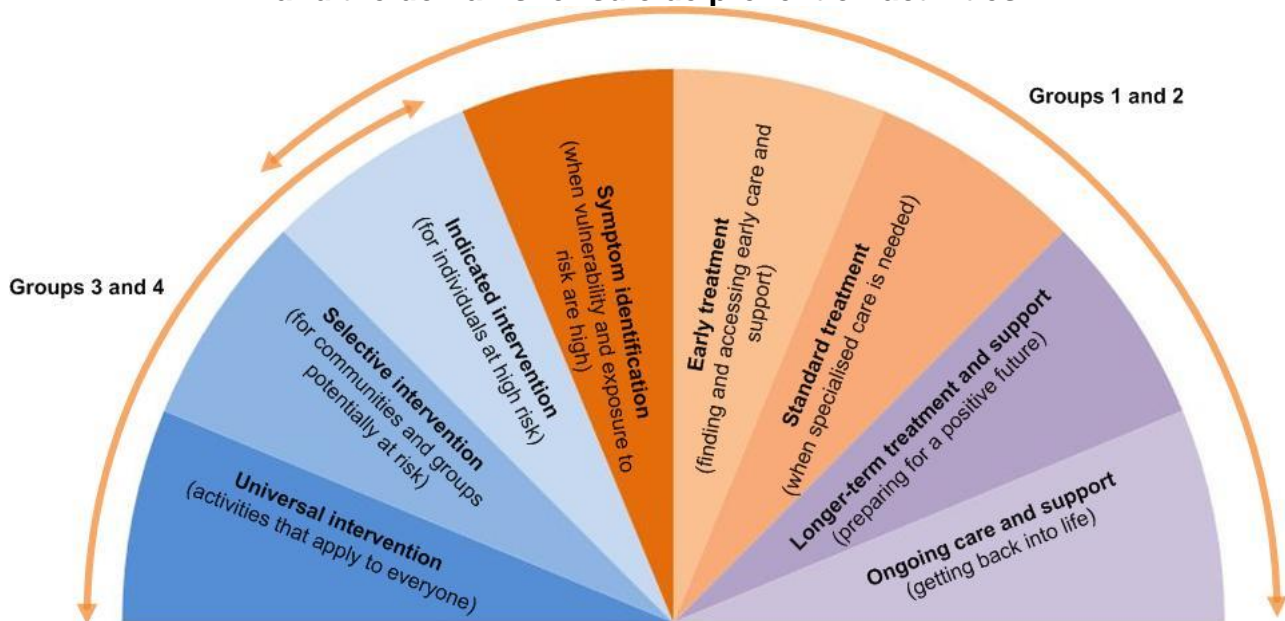
2.1.1 Background

The 2014 Investigation considered the research literature and suicide prevention strategies in effect in Western Australia during the investigation period together with the Office's analysis of the factors associated with suicide experienced by the 36 young people and identified that:

- the research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 titled *The spectrum of interventions for mental health problems and mental disorders* (**the Mrazek and Haggerty model**).¹ The Mrazek and Haggerty model divides interventions for mental health problems into three categories – Prevention, Treatment and Continuing Care – and into eight domains within these categories;
- the (then) Western Australian *Suicide Prevention Strategy 2009-2013: Everybody's Business* (**2013 State Strategy**) was informed by the Mrazek and Haggerty model;
- each of the four groups of young people experienced different factors associated with suicide; and
- the patterns in the factors associated with suicide experienced by the four groups of young people may be aligned with different, albeit overlapping domains of suicide prevention activities, as illustrated in Figure 2.

¹ Mrazek P and Haggerty R (eds), *Reducing risks for mental disorders: Frontiers for preventative intervention research*, National Academy Press, Washington, 1994.

Figure 2: Alignment between the patterns identified by the investigation and the domains for suicide prevention activities



Source: LIFE Framework and Ombudsman Western Australia

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

- **Group 1:** 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, with most also recorded as experiencing mental health problems and suicidal ideation and behaviour. Suicide prevention activities that may be aligned with the characteristics of the young people in Group 1 involve recognising and addressing the impacts of child maltreatment and other mental health problems through symptom identification; providing early, standard and/or longer term treatment; and providing ongoing care and support.
- **Group 2:** five young people who were recorded as either having been diagnosed with one or more mental illness, having a parent who had been diagnosed with a mental illness and/or demonstrating significant planning of their suicide. Suicide prevention activities that involve symptom identification and early, standard and longer term treatment of mental health problems may be aligned with the characteristics of the young people in Group 2, along with activities to provide ongoing care and support.
- **Group 3:** six young people who were recorded as having experienced few factors associated with suicide except for two young people who were recorded as having experienced suicidal ideation. Universal, selective and indicated interventions, such as those provided for under the 2013 State Strategy, may be aligned with the characteristics of the young people in Group 3. However, it may also be important to consider whether research into suicide by young people who did not experience the currently identified factors associated with suicide, such as those young people in Group 3, should be conducted to develop a greater understanding of this group and inform future suicide prevention activities.

- **Group 4:** five young people who were recorded as having experienced few factors associated with suicide, and were all recorded as having demonstrated impulsive or risk taking behaviour. Four of these young people were also recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. Universal interventions may be aligned with the characteristics of the young people in Group 4. In addition, three young people in Group 4 were Aboriginal, and three young people resided in a regional, remote or very remote area. Accordingly, selective and indicated interventions, which target communities and individuals at risk, may also be aligned with the characteristics of the young people in Group 4.

2.1.2 Mental Health Commission report

In addition to considering publicly available information, 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 a range of information in:

- reports prepared by the Mental Health Commission;
- meetings with the Mental Health Commission; and
- *Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020)*.²

The Mental Health Commission relevantly informed the Office that:

The state-wide suicide prevention strategy, *Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020)*, is a population based strategy which involves targeted and specific interventions, as well as universal and population-based interventions.

Suicide Prevention 2020 was developed using contributing factors to suicide across life stages, evidence-based prevention and intervention approaches, and the then most current data and research in a Western Australian context.

With specific regard to giving effect to the recommendation, the Mental Health Commission informed the Office that:

Consideration was given to, and *Suicide Prevention 2020* specifically addresses, the findings of, a number of reports; including the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people (2014)* report and related recommendations.

Further to this, the Mental Health Commission had previously made a written submission to the Education and Health Standing Committee's Inquiry into Aboriginal Youth Suicides in 2016 which stated that:

² Mental Health Commission, *Suicide Prevention 2020: Together we can save lives*, Government of Western Australia, Perth, 2015, [pp.](#) 6-7.

The MHC is not addressing the four individual groups separately. Broad categorisation for groups of young people is considered less effective than a risk-based approach, which addresses all young people becoming at-risk of mental health problems, including self-harm.³

The Education and Health Standing Committee's subsequent report of its Inquiry into Aboriginal Youth Suicides, *Learnings from the message stick*, noted that:

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

While the MHC says that it accepts the *Ombudsman 2014* report recommendation to develop differentiated strategies, it also states that Suicide prevention 2020 does not address the four groups separately, preferring a risk-based approach.

Recommendation 22 [of the *Learnings from the message stick* Inquiry]

*That the Mental Health Commission immediately make publicly available the Suicide Prevention 2020: Together we can save lives Implementation Plan, Aboriginal Implementation Plan and Youth Engagement Strategy.*⁴

The Office has carefully considered the Mental Health Commission's reported risk-factor based approach used in Suicide Prevention 2020. Having done so, the Office considers the Mental Health Commission's risk-factor based approach to be similar to the factors associated with suicide used to identify groups of young people who died by suicide in the 2014 Investigation:

When developing strategies relating to preventing and reducing suicide by children and young people ... For example, children who lose a parent to suicide are three times more likely to die by suicide than children who live with both of their parents. In light of this fact, the Mental Health Commission awarded a contract for delivery of the pilot Children & Young People Responsive Suicide Support (CYPRESS) program, a support service for children between the ages of 6 and 18 years bereaved by suicide on the basis of evidence that children bereaved by suicide are three times more likely to go on to complete suicide themselves. This program is the second of its kind in the world, and will contribute to the emerging body of evidence regarding suicide prevention.

Accordingly, steps have been taken to give effect to Recommendation 1.

³ Mental Health Commission, Submission No. 38 to the Education and Health Standing Committee *Inquiry into Aboriginal Youth Suicides in Remote Areas*, 30 August 2016, Attachment 2, p. 1.

⁴ Education and Health Standing Committee, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*, Report No. 11, Legislative Assembly, Parliament of Western Australia, Perth, November 2016, pp. 114 -115.

2.2 Recommendation 2

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

2.2.1 Background

In addition to the analysis and findings relevant to Recommendation 1, the 2014 Investigation found that 11 of the 36 young people (31 per cent) were recorded as having experienced few factors associated with suicide, as follows:

- **Group 3:** six young people, none of whom were recorded as having allegedly experienced child maltreatment, a mental health problem or adverse family experiences. All six young people were recorded as being highly engaged in school and/or sport; and
- **Group 4:** five young people, none of whom were recorded as having allegedly experienced child maltreatment, a mental health problem or adverse family experiences. Four young people in Group 4 were recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. In addition, the Office observed that all five young people were recorded as having demonstrated impulsive or risk taking behaviour.

Through this analysis of the factors associated with suicide experienced by the young people in Groups 3 and 4, and their contact with State government departments and authorities, the Office identified a gap in the current evidence base relating to risk factors associated with youth suicide, noting that further research should be conducted to develop a greater understanding of this group and inform future suicide prevention activities.

2.2.2 Mental Health Commission report

In addition to considering publicly available information, the Office requested that the Mental Health Commission inform the Office of the steps taken to give effect to Recommendation 2. In response, the Mental Health Commission provided a range of information in:

- reports prepared by the Mental Health Commission; and
- meetings with the Mental Health Commission.

The Mental Health Commission relevantly reported to the Office that:

The MHC prioritises funding of evidence-based and evidence-informed projects that will contribute to achieving Suicide Prevention 2020's goal of reducing deaths by suicide and suicide attempts in Western Australia by 2025. Commissioning of projects also occur given the fixed budget of \$26 million over four years for Suicide Prevention 2020, and the State's fiscal position.

A significant proportion of the total funding under Suicide Prevention 2020 has been committed to addressing the needs of young people. For example, the MHC

spent approximately \$2,937,924 on projects and services specifically aimed at reducing youth suicide in 2016/17 financial year, representing 47.88% of the \$6,134,990 total spent. The MHC expects to spend in excess of \$2.7 million on this program of works in 2017/18.

Community demand directed the funding opportunities available through the competitive Suicide Prevention Grants program. This program has enabled local government and not-for-profit organisations to apply for grants of up to \$20,000 to undertake evidence-based suicide prevention activities tailored to meet the need of local communities. Approximately \$221,231 has been awarded to organisations to deliver training specifically targeted at youth suicide prevention, such as Youth Mental Health First Aid and Gatekeeper training, which broadly benefits young people in the financial years 2015/16 to the present.

Relevant projects funded by the MHC, although not funded under the Suicide Prevention 2020, which may be relevant to [Groups 3 and 4] ... include:

- School Alcohol and Other Drug Education (SDERA). SDERA helps children and young people make smarter choices by providing a resilience approach to road safety and alcohol and other drugs education, though not specifically addressing suicide.
- Aussie Optimism. Evidence-based 5-stage mental health program for school children in Years 1 to 8, utilising empirically validated psychological and educational techniques; and designed for school psychologists and teachers to use with a whole class. Teaches children practical skills and strategies aimed to promote mental health wellbeing and prevent emotional problems such as depression and anxiety.
- Changing Minds. Teaches secondary school students about mental health. Assists teachers in recognising signs of mental illness to enable early intervention. Focusses on improving students understanding of, and attitude towards mental health and the perceived benefits and barriers to seeking help.

The MHC's Think Mental Health public education campaign (the Campaign) is dedicated to improving the Western Australian community's mental health and wellbeing, and reducing the risk of suicide. Baseline data has included school students aged 15-17 years and youth aged 18-25 years.

The original implementation documents for Suicide Prevention 2020 included a Youth Engagement Strategy, which was developed in consultation with young people in Western Australia. A variety of young people were consulted including some in the 14 – 17 year demographic identified in Recommendation 2.

A revised Performance and Outcome Framework, a detailed Program Logic, and a comprehensive Evaluation Plan were developed as per a request from the Department of Treasury Western Australia, as part of broader reaching good governance and oversight initiatives. These new documents superseded the Youth Engagement Strategy, which was one of a number of point-in-time internal working documents which are no longer fit-for purpose.

The Mental Health Commission also reported to the Office that:

The Response to Suicide and Self-Harm in School Program (School Response) is a coordinated mental health crisis response strategy delivered jointly by the Department of Education, the Child and Adolescent Mental Health Service and Youth Focus Inc., with funding from the MHC. The School Response aims to ensure that school aged youth experiencing issues associated with depression, self-harm and grief from bereavement by suicide have access to necessary services and support. It encompasses prevention, intervention and postvention activity in schools across Western Australia, including in metropolitan, regional and remote areas.

This project engages directly with children and young people who are put at-risk by their exposure to suicide. This project operates in all schooling environments, inclusive of government, Catholic and independent schools.

Accordingly, steps have been taken to give effect to Recommendation 2.

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2.3 Recommendation 3

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

2.3.1 Background

The 2014 Investigation noted that the Western Australian *Suicide Prevention Strategy 2009-2013: Everybody's Business* was focused on the Prevention category of the Mrazek and Haggerty model through activities that are 'targeted universally at the general population ... focus on selective at-risk groups, or ... can be directed to those at risk as required'.⁵

The Office's analysis indicated that:

- suicide prevention activities in the Prevention category may be important and should continue;
- the factors associated with suicide experienced by 25 of the 36 young people (69 per cent) may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model;
- all of the 36 young people had recorded contact with State government departments and authorities during their lives and 31 of the 36 young people (86 per cent) had contact with multiple State government departments and authorities including the (then) Department of Health Child and Adolescent Mental Health Service, the Department of Education and the (then) Department for Child Protection and Family Support; and
- the Office's findings and recommendations in relation to each of these agencies (as set out in Chapters 7 to 9 of the 2014 Investigation) align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

2.3.2 Mental Health Commission report

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 a range of information in:

- reports prepared by the Mental Health Commission; and
- meetings with the Mental Health Commission.

The Mental Health Commission relevantly informed the Office that:

⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business*, Department of Health, Perth 2009, p. 30.

The MHC is a commissioning agency. The change in scope required to address the Treatment and Continuing Care categories of suicide prevention would have required significant additional funding and resources beyond the \$26 million over four years which was secured. Consideration for the proposal was that the State had reached a limit to the dedicated funding available for the Strategy, and any further expansion should be made within the general context of general mental health funding for treatment and continuing care.

Additionally, the Mental Health Commission reported to the Office that:

With regards to continuing care, the Suicide Prevention 2020 has prioritised the following activities:

- Funded by the MHC, 360 Health and Community, through their Active Life Enhancing Intervention program [ALIVE], will be conducting a project in the Perth metropolitan area, working with people who have attempted suicide through assertive support to engage with appropriate treatment services post release from hospital.
- The implementation of Suicide Prevention Coordinators in each health region across the State by June 2017. Key function of the coordinators will be to improve the implementation of appropriate postvention services for individuals and families directly affected by suicide at a local community level.

The stated aim of the Mental Health Commission's, *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (**Better Choices Better Lives**) is to improve the treatment and continuing care provided to children and young people experiencing mental health problems and/or at risk of suicide, by providing age appropriate services across the mental health and alcohol and other drug service spectrum. Better Choices Better Lives relevantly states that:

INFANTS, CHILDREN AND ADOLESCENTS (ICA)

Ages 0 to 15 years (Mental Health) and ages 0 to 11 years (Alcohol and Other Drug)

Supporting the mental health and wellbeing of the ICA age group, as well as protecting them from harms associated with alcohol and other drug use is important so they are able to realise their potential, cope with stress and be involved with family and other aspects of community life. The development of a range of effective, strengths-based, age appropriate mental health, alcohol and other drug services and programs to support the health of the ICA age group and their families is an early priority of the Plan.

This is particularly important for people in the ICA age cohort who are highly vulnerable (e.g. children in care, children of parents with mental health, alcohol and other drug problems). Dedicated ICA services are included in *Prevention, Community Support Services, Community Treatment Services, Hospital-Based Services* and *Specialised Statewide Services* section. Services for children aged 10 years and over are included in the *Forensic Services* section.

YOUTH

Ages 16 to 24 years (Mental Health) and ages 12 to 17 years (Alcohol and Other Drug)

Youth experience the highest prevalence and incidence for mental illness across the lifespan. Young people with co-occurring mental health, alcohol and other drug problems are particularly at risk of poor outcomes because their age and stage of physical, neurological, psychological and social development makes them vulnerable. Increasing service capacity to meet the needs of young people, and the expansion of dedicated youth mental health, alcohol and other drug services across all service streams are urgent priorities to progress.

... We aim to configure the existing and new mental health services into the following new age streams: infant, child and adolescent (0-15 years); youth (16-24 years); adult (25-64 years); and older adult (65 years and above) as soon as possible, in order to introduce a new, dedicated youth stream. All services will be expected to meet the needs of young people with co-occurring mental health, alcohol and other drug problems. Youth mental health services must also have the capability to identify and treat early psychosis.

Dedicated youth services have been referred to in various parts of the Plan: *Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services, Hospital-Based Services, Specialised Statewide Services, and Forensic Services.*⁶

Although Better Choices Better Lives does not expressly incorporate Recommendation 3, it does set out a number of key actions relating to children and young people which are thematically similar to Recommendation 3, including key actions 5, 10, 26, 27, 28, 46, 53, 55, 56, 57 and 78 relating to treatment and continuing care.⁷

Better Choices Better Lives also notes the importance of interagency collaboration and the need to develop collaborative approaches to developing and providing mental health treatment services in Western Australia, as follows:

Various stakeholders must be involved in the planning, commissioning and delivery of forensic mental health, alcohol and other drug services. These include the Mental Health Commission, the Disability Services Commission, the Department of Health, the Department of Corrective Services, Western Australian Police, the Department of the Attorney General, the Department of training and Workforce Development, the Department of Education, the Department of Housing, the Department for Child Protection and Family Support, non-government organisations, consumers, carers, families and other stakeholders.⁸

⁶ Mental Health Commission, *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, Government of Western Australia, Perth, 2015, pp. 24-25.

⁷ Mental Health Commission, *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, Government of Western Australia, Perth, 2015, pp. 174-187.

⁸ Mental Health Commission, *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, Government of Western Australia, Perth, 2015, pp. 174-187.

From the information contained in Better Choices Better Lives, Suicide Prevention 2020 and the Mental Health Commission's reports to the Office, consideration was given to the most appropriate strategic framework to plan for investment and reform in the Treatment and Continuing Care categories of suicide prevention in Western Australia, as proposed in Recommendation 3.

Accordingly, steps have been taken to give effect to Recommendation 3.

2.4 Recommendation 4

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

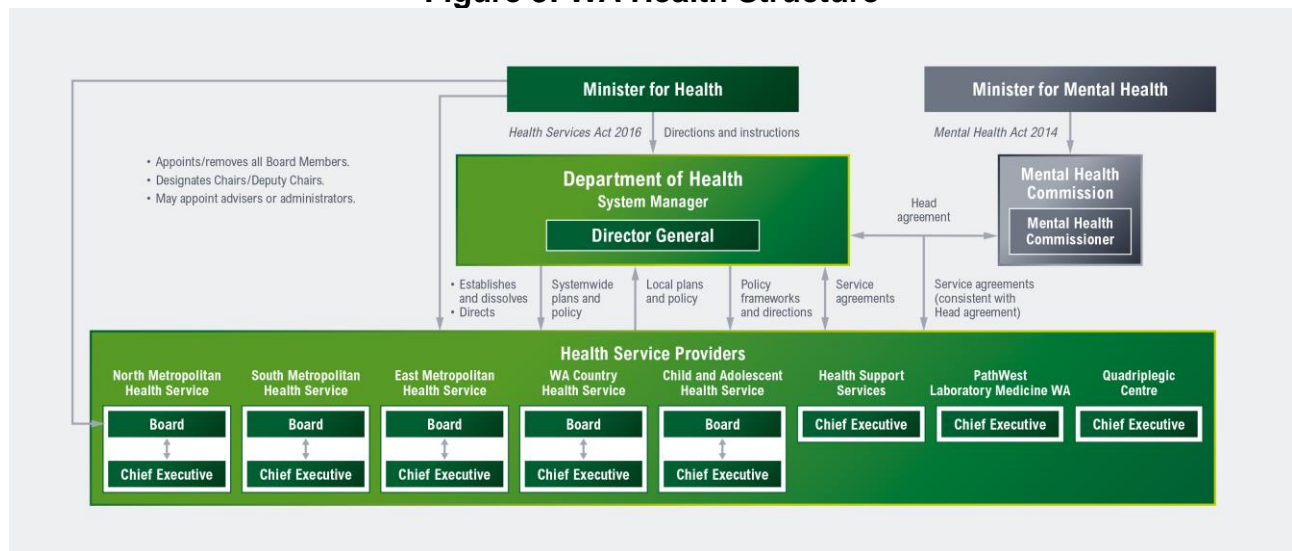
2.4.1 Background

The 2014 Investigation considered the research literature identifying mental ill-health as a factor associated with suicide; the role, scope and services provided by the (then) Child and Adolescent Mental Health Service (**CAMHS**); legislation relating to mental health services in Western Australia and CAMHS policies and standards for referrals, acceptance, risk assessment and discharge planning.

Accordingly, given the central role of the CAMHS in providing assessments, case coordination and treatment services for children and adolescents under 18 years of age who have severe, complex and persistent mental illness, the Office recommended that its findings be considered in future service delivery and planning decisions.

Since the 2014 Investigation, Western Australia's public health system has transitioned to a new structure, following the commencement of the *Health Services Act 2016* on 1 July 2016 (known as **WA Health**).

Figure 3: WA Health Structure



Source: Department of Health

Under the *Health Services Act 2016*, each Health Service and Health Support Service is established as a separate statutory authority, governed by a board and/or chief executive, as shown in Figure 3. The former 'CAMHS' has transitioned from being part of the Department of Health to part of the new, stand alone Child and Adolescent Health Service (**CAHS**). However, Child and Adolescent Mental Health Services (that is, public mental health care for children and young people) are provided by both CAHS and the WA Country Health Service (**WACHS**) in Western Australia.

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

- **Mental Health Inpatient Unit**, Ward 5A. WA's only Authorised Mental Health Inpatient Unit for patients aged 0 to 16.
- **Statewide Eating Disorder Service**, which provides an outpatient and day program for children and young people with eating disorders.
- **Statewide Gender Diversity Service**, which provides assessment, care and treatment of gender diversity related issues, including assessment and approval for medical intervention in teenagers;⁹ and
- **Paediatric Consultation Liaison**, which provides support for children and adolescents who are patients at Perth Children's Hospital and have mental health issues relating to their medical conditions or their treatment plan;¹⁰ and
- **Mental Health Support Line**.

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

The following specialist CAHS CAMHS programs are located in the community:

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

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

¹⁰ Department of Health, Child and Adolescent Health Service – Mental Health PCH Mental Health, CAHS, Perth, viewed 9 September 2018, <<https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Mental-Health-Service/Our-services/PCH-Mental-Health>>.

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

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

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

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

Under sections 26 and 27 of the *Health Services Act*, all Health Service Providers, including CAHS CAMHS and WACHS CAMHS are required to comply with the Department of Health's *Mental Health Policy Framework*, which includes the *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards (CRAM)* considered in the 2014 Investigation, and the new *Clinical Care of People Who May Be Suicidal Policy*.¹¹

2.4.2 Department of Health report

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 a range of information in:

- reports prepared by the Department of Health; and
- meetings with the Department of Health.

The Department of Health relevantly informed the Office that:

Child and Adolescent Mental Health Service (CAMHS) has recently redesigned services in order to improve the outcomes of children and adolescents presenting with self-harm and suicidality. Touchstone, an evidence-based day, outpatient and consultation/supervision service for adolescents with persistent deliberate self-harm and suicidality is now operating with a model of care based on Mentalisation Based Therapy (MBT).

Broader changes to the provision of mental health services are the responsibility of the Mental Health Commission.

The Review of admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia by Professor

¹¹ Department of Health, *Mental Health Policy Framework*, Government of Western Australia, Perth, 2018, viewed 9 September 2018 <http://www.health.wa.gov.au/circularsnew/frameworks/Mental_Health.pdf>, p. 2.

Bryant Stokes in 2012 stated the following in relation to children and young people:

“Simplifying access and entry processes, improving pathways of referrals, improving after-hours and emergency response services irrespective of location, and closing identified gaps should each be given strategic priority.”

The Stokes Review contained 117 recommendations, including 26 recommendations under the theme of Children and Youth. The Children and Youth recommendations have been implemented by the Office of Mental Health (now the Mental Health Unit) and Health Services, including the Child and Adolescent Mental Health Service (CAMHS) within the Child and Adolescent Health Service (CAHS), or will be addressed through the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025.

Many of the Stokes Review recommendations are consistent with the findings of the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people (‘the investigation’).

The following are examples of Stokes Review initiatives that address the findings of the investigation. Some of these initiatives also provide mechanisms for the ongoing consideration of the findings in the development of Statewide policies and planning to support mental health services for young people:

- A Mental Health System-wide Clinical Policy Group was developed in October 2014, including representation from CAMHS
- A Mental Health Clinical Reference Group started in January 2016; including representation from CAMHS and Youth Mental Health (the co-chair of the reference group represents Youth Mental Health)
- A Mental Health Network was launched in October 2014, and a Youth Sub Network has also been established
- An Operational Directive on the mandatory use of State-wide Standardised Clinical Documentation for Mental Health Services was issued in June 2014, including a Risk Assessment and Management Plan (currently on PSOLIS as Brief Risk Assessment), Treatment, Support and Discharge Plan (Currently on PSOLIS as Management Plan) and Care Transfer Summary for children and adolescent mental health services
- CAMHS also offers a child and family friendly recovery plan

CAHS reported to the Office that:

CAHS CAMHS has an access policy that upholds the following:

- Services must be available to children presenting with a range of mental health concerns (reflected in behavioural, cognitive and/or emotional difficulties, including alcohol, drug, and substance issues) and across the spectrum of development.
- Priority must be given to those children with acute and/or severe mental health presentations.

The **CAMHS Clinical Assessment Policy and Risk Assessment and Management Policy:**

- Updated to align with the Department of Health (DoH) Statewide policies, *Clinical care of people who may be suicidal* and *Clinical care of people with mental health problems who may be at risk of becoming violent or aggressive* (includes self harm)
- Outlines additional requirements during the initial assessment and risk assessment for children who may be at risk of suicide or self harm. Requirements include:
 - During the initial assessment and risk assessment the clinician must use clinical judgement. The Assessment of risk must include, but are not limited to, consideration of:
 - Serious mental illness, including neurodevelopmental comorbidities
 - Substance abuse
 - Childhood experience
 - Self-harm
 - Systemic issues, including any child protection concerns in the current context
 - From the assessment, a Safety Plan is developed that formulates strategies that explore distractions that the consumer has identified to reduce the likelihood of self-harm or suicide. The plan outlines actions to be taken, when [and] by whom in the event of a crisis.
 - The plans must be revised and updated at points of significant transitions in care, change/deterioration in clinical state, post incident and times of heightened risk.

The **CAMHS Transitions in Care policy** is a combined clinical handover and discharge and transfer policy, supported by a 'best principles and guidelines' document to support the policy. The policy covers:

- Combined CAMHS clinical handover policy and discharge and transfer policy. Created a best principles and guidelines document to support the policy
- Discharge planning:
- On entry to a service, as part of the development of a care plan, discharge planning must be included. The discharge plan must be reviewed as part of each formal clinical review process and documented on the management plan.
- The management plan must include a discharge component. It must include the treatment and support that will be offered to the child and their parent when the child is discharge from the service.
- The management plan must be prepared in collaboration with the child and parent as soon as possible after admission to the service, be reviewed regularly and as necessary, and must be discussed and recorded in a way that the child understands.
- The Policy dictates that patients of concern are managed appropriately – Management of a deteriorating patient must be escalated as soon as deterioration in a patient's condition is identified. Clinical handover must be face to face and written. Documentation must include:
 - Pertinent clinical information including a management plan as per the WA Health Acute Deterioration Policy;
 - Time and date of clinical handover; and
 - Details of at least one of each of the providing and receiving clinicians.
- The Policy was endorsed in February 2018.

In addition, WACHS informed the Office that:

Since the time of [the 2014 Investigation], WACHS has established small MHC funded specialist youth mental health services in 2 of its 7 regions and has some additional WAPHA funded youth [service] provision. Other regions have developed some degree of specialist provision in response to local need within existing funding. A formal youth stream for reporting is currently being established, and the WACHS Mental Health Strategy clearly identifies the need for further development of WACHS Youth mental health services.

Relevantly, the WACHS *Mental Health and Wellbeing Strategy 2019-24* identifies 'prevention and early intervention', 'reducing stigma', 'bringing care closer to home', and 'equitable access to health care' as drivers for change. It also targets 'disadvantage and inequity in services access and outcomes for country people', in particular for vulnerable groups including 'people who have experienced complex trauma', 'children and youth', and 'Aboriginal people'.

Key performance measures and indicators for the Strategy also include:

- Suitable E-learning package to address 'Principles and Best Practice for the Care of People Who May Be Suicidal' is developed and implemented in 100% of regions by 2020;
- Establish processes to allow information sharing between WACHS and other service providers in 100% of regions by 2022;
- Suicide Risk Assessment Training on-line completed by 80% of emergency department clinicians by 2023;
- Mental health, substance use and cultural competency education and training packages developed and delivered to 80% of staff in each region by 2022; and
- An e-Learning package will be developed and available for all WACHS staff to undertake on the principles of trauma informed care, with 80% of relevant staff in each region receiving training by 2024.

Accordingly, steps have been taken to give effect to Recommendation 4.

2.5 Recommendation 5

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

2.5.1 Background

In the 2014 Investigation, the Office found that 12 of the 36 young people were recorded as having been diagnosed with a mental health disorder and all were referred for assessment by CAMHS during their lives.

The Office reviewed the policies providing the criteria under which a referral to CAMHS should be accepted, and the files for the young people referred to CAMHS. The Office found that there were differences between the experiences of young people in Group 1 and Group 2 in their interactions with CAMHS, particularly in relation to acceptance of referrals by CAMHS, namely that:

- all eight people in Group 1 who were recorded as having been diagnosed with a mental health disorder had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives;
- during the last year of their lives, six of the eight young people in Group 1 were referred to CAMHS again but three young people were not accepted by CAMHS even though they met the priorities for acceptance;
- the remaining three young people in Group 1 referred to CAMHS in the last year of their lives had their referrals accepted; and
- all of the four young people in Group 2 diagnosed with a mental health disorder received their diagnosis during the last two years of their lives. Each was also referred to CAMHS and had their referral accepted.

2.5.2 Department of Health report

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 a range of information in:

- reports prepared by the Department of Health; and
- meetings with the Department of Health.

The Department of Health relevantly informed the Office that:

The Access to CAMHS policy and Entry Protocol for each team clearly outlines access and entry criteria. Community CAMHS supports the implementation of the Entry Protocol by the use of a referral management form and, after recent clinical reform, ensures that the same criteria for entry is applied across all of the ten Community teams in the metropolitan area.

Community CAMHS has a responsive and culturally appropriate pathway into the service for Aboriginal children and young people as outlined in the CAMHS Aboriginal Mental Health Service Model of Care.

With the recent integration of the Acute intervention stream into Community CAMHS, there is an agreed protocol (flowchart) that ensures that CAMHS accepts all referrals made by a mental health professional for a Choice appointment with no further triage within CAMHS.

The new Model of Care (MoC) for the CAMHS Inpatient Unit (IPU) informs the process for admission including criteria, referral pathways and patient journey from pre admission to discharge. The MoC also includes information regarding planned admissions and will be supported by a clinical package. Planned admissions are preceded by collaborative engagement with the referrer to agree goals of admission etc.

A supplementary report provided to the Ombudsman in response to a question about the methods used to 'ensure that CAMHS applies the priorities for acceptance' further explained that:

CAMHS has responsibility for ensuring that its priorities for acceptance are appropriately applied. The System Manager monitors HSP/system-wide outcome measures, not HSP operational matters.

In Specialised CAMHS services, all referrals are discussed in meetings with key personnel (clinical, admin) or key stakeholders. ... In Community CAMHS, referrals are processed for each team by the Service Manager, Head of Service and the Choice Coordinator resulting in a Choice Appointment for all accepted referrals received (as some referrals do not reach the high threshold for access to State funded Community CAMHS). This ensures that 100% of appropriate referrals have access to Community CAMHS. Entry Protocols are reviewed at SBAR [Situation-Background-Assessment-Recommendation] meetings. In Acute CAMHS, the CAMHS Inpatient Unit holds planned admission meetings and maintains a record of all referrals and outcomes, whether admitted or not. KPI's in relation to access timeframes are monitored.

CAMHS has a robust system of responding to and monitoring consumer feedback. There are a range of feedback mechanisms available to families who attend CAMHS services, including Experience of Service Questionnaires, the CAHS Child and Family Engagement Service (which operates under the mandated WA Health Complaints Management Policy), and the Patient Opinion website. All feedback is reviewed on a regular basis (maximum quarterly) to identify any opportunities for service improvement. Negative feedback regarding access and entry typically relates to families not understanding the reasons for their child not being accepted into a CAMHS service, or having to wait to access a service.

In meetings, the Department of Health informed the Office that:

- the receiver of a referral is required to review the patient's records on the Psychiatric Services On-Line Information System (**PSOLIS**) and service access history;

- a major focus in the last three to four years has been allowing greater read-all access to PSOLIS. CAMHS also keeps a record of all referrals that are not accepted, so that any future referrals can be assessed in context;
- it does not have the resources to audit decisions about priorities for acceptance at CAMHS, but that SBAR meetings act as a form of live governance and it is using implementation strategies to close the gap between policy and practice. It is using focus groups to find out how much staff know and how it can cause certain aspects of practice to be embedded.

CAHS reported to the Office that:

Following the devolution of the Acute Community Intervention Team (ACIT) into Community CAMHS in May 2016 acute services are very much integrated into the community setting, ensuring a quick response to urgent referrals.

Historically, prior to 2016 the Mental Health Commission reported that children were waiting 6-8 months for non-urgent referrals and several months for priority referrals. In response to this the Choice and Partnership Approach (CAPA) was adopted, which is based on demand and capacity theory and was developed specifically for CAMHS services.

CAPA was fully implemented across all ten Community CAMHS services by July 2015. Since then wait times have vastly improved across all Community CAMHS sites. During the last two years pressure has begun to mount on Community CAMHS services as the growing demand exceeds capacity. Despite the efficiency of CAPA, non-urgent referral wait times are under significant pressure.

Nevertheless, after the integration of ACIT into Community CAMHS sites, urgent referrals are responded to within 2 days.

The Experience of Service (ESQ) has been rolled out across CAHS CAMHS and is another mechanism through which young people and families can give feedback on their experience of care.

CAHS CAMHS will be transitioning from the ESQ to the Your Experience of Service (YES) survey by the 30 June 2020. A trial of the YES was recently undertaken across CAHS CAMHS for a period of 3 months.

In addition, WACHS informed the Office that:

WACHS regularly audits against the statewide requirements for documentation and has policy to describe the required access and referral management processes for all age groups.

Accordingly, steps have been taken and are proposed to be taken to give effect to Recommendation 5.

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2.6 Recommendation 6

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

2.6.1 Background

In the 2014 Investigation, the Office found that:

- two young people (of the six young people in Group 1 who were referred to CAMHS during the last year of their lives) were on the waitlist for CAMHS or waiting for an initial appointment between two and five months before they died; and
- one young person (of the four young people in Group 2 who were referred to CAMHS and accepted to receive services) was waitlisted to receive services at the time of their death.

2.6.2 Department of Health report

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 a range of information in:

- reports prepared by the Department of Health; and
- meetings with the Department of Health.

The Department of Health and CAHS relevantly informed the Office that:

The CAMHS Bed coordination role is currently undertaken by the Inpatient Unit Clinical Nurse Manager in the Perth Children's Hospital Emergency Department. This bed coordination role will move to the CAMHS IPU in the near future to assist with timely access to available beds and less 'handling' of information. Draft flow charts have been developed to support this, as well as a draft checklist for information required from the referrer to ensure that all appropriate information is received at initial referral. CAMHS is currently exploring options for utilising Electronic Bed Management (EBM) when bed management moves to IPU.

The CAMHS Acute Community Intervention Team (ACIT) service has recently been realigned with community-based CAMHS services. Moving the ACIT service into Community CAMHS teams has increased the number of appointments available for urgent mental health assessments, which will in turn improve access to the service for children and families, allow them to seek support closer to home, and result in fewer emergency department presentations across the metropolitan area. With the integration of the acute stream into Community CAMHS, all referrals (routine or urgent) are processed according to clinical need. CAMHS is committed to provide an initial Choice appointment within three working days for all referrals that have been identified as urgent.

Community CAMHS has also undertaken reform with the implementation of Choice and Partnership Approach (CAPA) across all community teams to improve the timeliness of access to services. CAPA is a service delivery framework that aims to engage young people and their families in care and therapeutic interventions while optimising service efficiencies and managing supply and demand within the service. There are no longer waitlists for access to the services and shorter waiting periods than previously.

Current combined mean time from Receipt of Referral (RoR) to the Choice appointment is 26 days (consumer expectation is 28 days); time of RoR to the Partnership appointment is 35 days (consumer expectation is 56 days). 60% of teams are achieving a mean of under 28 days for RoR to Choice, and 50% of teams are achieving a mean of under of 56 days for RoR to the Partnership appointment [as reported to the Ombudsman in December 2019]. This is a symptom of high referrals and no increase in clinicians in the past two decades.

Staff can attend interagency case conferences at any time during the referral process.

Community CAMHS has regular monthly meetings with Department of Child Protection and Family Support and the Child Development Services within the Child and Adolescent Health Service, where specific complex cases are discussed and referrals are facilitated.

CAHS reported to the Office that:

CAMHS does not have a waitlist in the sense that medical health service may have a waitlist. Community CAMHS referrals are allocated to a Community CAMHS site on the basis of catchment area. It is a performance indicator for CAMHS referrals that a patient is seen within the consumer set target of 28 days of referral, however as pressure increases on Community CAMHS due to population growth and an increase in referrals in the context of stagnant FTE many Community sites are exceeding 28 days.

The current median time between Community CAMHS referral and a referred young person attending their first Choice and Partnership Appointment (CAPA) is 52 days [as of September 2019].

The increase in demand for CAHS Community CAMHS services in the context of stagnant clinical FTE has resulted in a situation in which only the most acutely unwell young people are able to access CAHS CAMHS services.

- There has been significant population growth in the 0-17 year old population since 2013; especially in the outer metropolitan areas, which has been reflected in a steady increase of referral numbers to Community CAMHS. In the 2017/18 financial year CAHS CAMHS experienced a 15.5% increase of demand for its non-admitted services.
- Despite this, there has been no increase to Community CAMHS [funding] since 1992.
- 15% of WA's children and adolescents (4-17 years) have a mental disorder; with 3.5% having a mental health disorder of moderate severity; and 2.1% having a mental health disorder of severe impact.
- In 2017, the number of children and young people living in the Perth metropolitan area was 593,584 of which approximately 82,500 can be assumed to have a mental health disorder.

- In 2018, 4,675 children and young people accessed CAHS CAMHS community services, which is less than 6% of the children and adolescents with a mental health disorder.
- The ability to maintain responsive services and timely access to mental health care is becoming increasingly difficult, with Community CAMHS experiencing higher levels of acute referrals. The ability to respond to young people with an emerging disorder is severely limited and opportunities for early intervention are non-existent.

Commonwealth funded Headspace Youth mental Health Services (for young people aged 12-25 years) provide primary mental health services only. Leaving a gap between Tier 1 Services, such as Headspace and Tier 3 Specialist mental health services such as CAMHS.

Children and young people with more moderate to severe and complex mental health issues are slipping through the gaps in care. Described as the 'missing middle' these young people need more specialized, intensive and extended care than is currently available within primary care, however, they are not yet acutely or severely ill enough to reach the high threshold for access to State funded Community CAMHS.

WACHS also reported to the Office that:

WACHS provides CAMHS services in each of its seven regions and is implementing rurally adapted models of CAPA (Choice and Partnership Approach) across all of them.

WACHS regularly audits against the statewide requirements for documentation and has policy to describe the required access and referral management processes for all age groups.

WACHS does not have waiting lists for its CAMHS services. However, it should be noted that access to psychological therapies is limited in rural and remote parts of the state, and rural children and young people needing access to inpatient beds are at significant disadvantage, as there are no child or youth inpatient mental health beds outside metropolitan Perth.

Accordingly, steps have been taken and are proposed to be taken to give effect to Recommendation 6.

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2.7 Recommendation 7

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

2.7.1 Background

The 2014 Investigation found that three young people in Group 1 were referred to CAMHS in the year prior to their death had their referral closed due to:

- unsuccessful attempts to contact;
- being referred to a specific CAMHS service but the referral was not pursued; or
- the referral not being accepted.

2.7.2 Department of Health report

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 a range of information in:

- reports prepared by the Department of Health; and
- meetings with the Department of Health.

The Department of Health relevantly informed the Office that:

It is standard practice across CAMHS to inform referrers of non-acceptance, as per the CAMHS Entry Protocol. Within Community CAMHS, following a Choice appointment, written information is sent to the referrer on the same day regarding the outcome of the referral. This includes information regarding the referral, the details of the assessment, and the plan going forward. Where indicated, CAMHS also provides written information regarding alternative services that may be appropriate for the young person if they are not suitable for CAMHS. The patient and family are also provided a copy of this information before they leave the clinic.

It has always been standard practice across CAMHS to inform referrers of non-acceptance, as per each team's entry protocol. For example:

Community entry protocol – *"Referrals requiring a different or alternative service: A letter is sent to the family and referrer with reasons for the decision and recommendations for an alternative service where indicated and more suitable."*

MST entry protocol - ... *'referrers being notified by team managers of alternative services'*.

EDP entry protocol – *'The triage team assist to set up alternative community assessment where possible to avoid an unnecessary tertiary assessment'*.

CAMHS IPU: *'If admission referrals are not felt to be clinically appropriate or not in the best interest of the child; then less restrictive and alternative options to admission are explored with the referrer'.*

There is currently no efficient way of monitoring this data. Noncompliance has not been raised in complaints.

CAHS reported to the Office that:

[CAHS is] dismayed by the Report's findings that some of the young people in the report had referrals to CAMHS that were rejected and not adequately followed up with referrers. This is a key issue that ... CAHS CAMHS seeks to eradicate through process and audit.

Referral Safeguards

All streams of CAMHS (Community, Specialised and Acute / Inpatient) have safeguards in place to ensure the status of the referral is communicated to the referrer. Each stream has an Entry Protocol dictating the criteria for accessing the service and what staff must do if a referral is rejected.

In Community CAMHS:

- All referrals received by Community CAMHS are processed, screened and responded to by the Choice Coordinator, or delegated person, within one working day of receipt of referral. Referrals received outside business hours will be processed the following business day.
- The Choice Coordinator/clinician redirects referrals where the young person is over 18 years of age or the request is not primarily for assessment and treatment of a mental disorder.

The Inpatient and Specialised Protocols are similar in nature.

In terms of CAMHS Policies, Procedures and Protocols ... the following steps are undertaken if a referral is not accepted in Community CAMHS:

- Young person is offered urgent or routine Choice appointment;
 - Urgent within 2 business days
 - Routine choice within 28 days
- Every referral is discussed at a Situation Background Assessment and Recommendation (SBAR) Meeting. These are attended by the relevant Community CAMHS Service Manager and Choice Coordinator.
- Results are recorded in the PSOLIS information system, this includes referrals that are not accepted.
- In these limited circumstances a young person may not be offered a Choice appointment:
 - Community CAMHS does not routinely accept referrals for a child whose referral primarily relates to assessment for Family Court, other legal purposes or for providing letters of support to other agencies. The child can be seen for their mental disorder but not for the sole purpose of the preparation of a report.
 - Neurodevelopmental disorders (e.g. Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), Fetal Alcohol Spectrum Disorder (FASD))

- Community CAMHS recommend referral to a Developmental Paediatrician for children who are the subject of concerns regarding neurodevelopmental disorders.
- Paediatricians may refer patients to Community CAMHS where there are moderate to severe co-morbid mental disorders.
- Community CAMHS do not accept referrals for diagnostic assessments for neurodevelopmental disorders.

CAMHS is aware that lack of follow up of referrals is a safety risk as this has been picked up by internal Root Cause Analyses (RCA) after clinical incidents. Audits are performed to mitigate this risk.

The introduction of the eReferrals across CAHS CAMHS may have a further impact on reducing any lack of follow up with referrers by adding another level of automatic follow up.

In addition, WACHS informed the Office that:

WACHS regularly audits against the statewide requirements for documentation and has policy to describe the required access and referral management processes for all age groups.

Accordingly, steps have been taken to give effect to Recommendation 7.

However, as identified in Chapter 8.2 of Volume 3, the Office's recent analysis of information obtained via individual child death reviews showed that of the seven deaths where a child or young person was referred to CAMHS but not accepted by the service, only two referrers were notified of this decision in compliance with policy requirements. For this reason, the Office will continue to monitor the notification to referrers when children or young people are not accepted by CAMHS through child death reviews and major own motion investigations.

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2.8 Recommendation 8

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

2.8.1 Background

In the 2014 Investigation, the Office considered, for the young people in Groups 1 and 2, the Department of Health's compliance with the *Clinical Risk Assessment and Management Policy* requirement for clinicians to undertake a risk assessment when a client:

- presents to an emergency department with suicidal intent and/or behaviour;
- is accepted by CAMHS outpatient services; and
- is admitted to a mental health unit.

The Office found, as a result of this analysis, that:

- risk assessments were not consistently undertaken for young people in Group 1 – particularly on presentation to an emergency department with self-harm, suicidal ideation and/or behaviour; and
- risk assessments were consistently undertaken for young people in Group 2.

2.8.2 Department of Health report

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 a range of information in:

- reports prepared by the Department of Health; and
- meetings with the Department of Health.

The Department of Health relevantly informed the Office that:

The CAMHS Risk Assessment and Management Policy aligns with the State-wide Clinical Risk Assessment and Management Policy and the State-wide Guidelines for Protecting Children (2015). Periodic documentation audits assess the completion and filing of risk assessment forms in the medical record. Audit results are tabled at the CAMHS executive governance meeting for review and action plans to improve compliance are established.

State-wide Standardised Clinical Documentation audits undertaken across CAMHS from January to December 2016 showed improved rates of utilisation of the CAMHS Risk Assessment and Management plan form. Audit results demonstrated 84% compliance with 'A comprehensive risk assessment is completed on admission/intake to the service'.

A guideline titled *Managing clinical risk after disclosure of child sexual abuse* has been developed and implemented across CAMHS to inform all CAMHS staff of how best to meet the needs of children and families when a disclosure of child sexual abuse has been made. CAMHS has also developed a guideline on sexual safety that is based on best practice within this area.

CAMHS are currently developing a policy for Progressive Risk Assessment (PRA). This will be 'rolled out' alongside a staff education package to ensure that comprehensive risk assessment is ongoing and informs each young person's management plan.

... a body of work has been undertaken to ensure audit results relating to risk assessments can be tracked electronically and over time. Audit data collected between January and December 2017 from 53 files, suggests [CAHS] CAMHS has maintained compliance with the completion of a comprehensive risk assessment on admission/intake to the service.

Data: April 2016 – December 2016				
Question (line 60)	Yes	Partial	No	N/A
A comprehensive risk assessment is completed on admission/intake to the service (i.e. Choice/Partnership)	145	9	8	3
Data: January 2017 – December 2017				
Question (line 60)	Yes	Partial	No	N/A
A comprehensive risk assessment is completed on admission/intake to the service (i.e. Choice/Partnership)	53	3	5	0

Audit result comparison by %			
Data: April 2016 – December 2016			
Question (line 60)	Yes	Partial	No
A comprehensive risk assessment is completed on admission/intake to the service (i.e. Choice/Partnership)	87%	5%	8%
Data: January 2017 – December 2017			
Question (line 60)	Yes	Partial	No
A comprehensive risk assessment is completed on admission/intake to the service (i.e. Choice/Partnership)	87%	4%	9%

In September 2017, CAHS MH introduced The Progressive Risk Assessment (PRA) tool. The tool captures risk at a particular point in time and supports staff to escalate a patient's care if deterioration in mental state/increase in risk is identified. It also supports staff to ensure risk is tracked throughout a patient's admission to provide health professionals with a visual guide to further understand changes in the patient's level of risk while an inpatient.

The Progressive Risk Assessment is not a replacement for a Risk Assessment and Management and Plan (RAMP) and both may need to be completed when indicated by the Progressive Risk Assessment or the CAHS MH Risk Assessment and Management policy.

An audit tool for PRA has been developed which will assess compliance with the following aspects of the use of the PRA:

- Completion of Progressive Risk Assessments at each shift change
- Completion of a RAMP when assessment shows evidence of deterioration
- Escalation to a medical professional for review when assessment shows evidence of deterioration
- Hand over to CN (Shift Coordinator) when assessment shows evidence of deterioration
- Update the ICMP when assessment shows evidence of deterioration
- The recording of interventions when assessment shows evidence of deterioration

The Chief Psychiatrist also informed the Office that:

... the Chief Psychiatrist Clinical Monitoring and Service Review Report for CAHS CAMHS looked at the extent to which risk assessments were undertaken and whether they were consistent with the Chief Psychiatrists Standards for Clinical Care – risk assessment standard. We found that CAHS CAMHS services consistently undertook risk assessments of children accepted by CAMHS, when they were first assessed.

CAHS reported to the Office that:

CAHS CAMHS has a Bilateral Agreement with the Department for Child Protection and Family Support (CPFS) [now part of the Department of Communities] defining the occurrence of Interagency Consultation liaison meetings and the respective roles of CAHS CAMHS and CPFS in communicating around children at risk. There are 6 FTE across the 10 CAMHS Community sites who are Child Protection Consultation Liaison staff whose role is solely to communicate with CPFS staff to ensure optimal communication around this patient cohort. Regular meetings are held with CPFS at all CAMHS Community sites.

Supporting Policies

The CAMHS Risk Assessment and Management policy establishes the requirements to be met by staff for risk assessment and management in CAMHS in order to promote excellent child health outcomes.

- CAMHS Risk Assessment and Management Policy has been updated to align with Statewide WA policies *Clinical care of people who may be suicidal* and *Clinical care of people with mental health problems who may be at risk of becoming violent or aggressive* (includes self harm).
- This Policy aligns with the *Clinical risk assessment and management (CRAM) in Western Australian Mental Health Services policy*; *Mental Health Act 2014*; *Clinician's Practice Guide to the MHA 2014*; *Chief Psychiatrist Standards of Clinical Care 2015*; *Clinical care of people who may be suicidal* statewide policy and *Clinical care of people with mental health*

problems who may be at risk of becoming violent or aggressive statewide policy.

- [The CAMHS Risk Assessment and Management policy] Outlines additional requirements during the initial assessment and risk assessment for children who may be at risk of suicide or self-harm. Requirements include:
 - During the initial assessment and risk assessment the clinician must use clinical judgement. The assessment of risk must include, but is not limited to, consideration of:
 - Serious mental illness, including neurodevelopmental comorbidities
 - Substance abuse
 - Childhood experience
 - Self-harm
 - Systemic issues, including any child protection concerns in the current context
 - From the assessment, a Safety Plan is developed that formulates strategies that explore distractions that the consumer has identified to reduce the likelihood of self-harm or suicide. The plan outlines actions to be taken, when [and] by whom in the event of a crisis.
 - The plans must be revised and updated at points of significant transitions in care, change/deterioration in clinical state, post incident and times of heightened risk.

The Mental Health Unit (Department of Health) Stokes Audit externally audited compliance with the CAMHS policy. The Stokes audit found that 99% of Community CAMHS files audited contained a completed SSCD Risk Assessment Management Plan (RAMP).

CAMHS also monitor compliance through their Documentation Audit.

- Progressive Risk Assessment (PRA) is a procedure at it is just for IPU. The Progressive Risk Assessment is a tool which captures risk at a particular time and supports staff to escalate a patient's care if deterioration in mental state or an increase in risk is identified. It also supports staff to ensure risk is tracked throughout a patient's admission to provide health professionals with a visual guide to further understand changes in the patient's level of risk while an inpatient. This process is outlined in the Progressive Risk Monitoring work instruction.
- PRA is audited and action plans are in place.

In addition, the WACHS *Mental Health and Wellbeing Strategy 2019-24* includes the following Key Performance Indicators:

- 'Patients experiencing mental health problems who present to ED will be reviewed with an appropriate plan for their ongoing care in line with their ED triage rating score', aiming to achieve 100% of mental health patients discharged from ED will receive a written care plan by 2022;
- 'Suicide Risk Assessment Training (MR 46)' on-line training completed by 80% of ED clinicians by 2023; and

- 'Improved compliance with Chief Psychiatrist's Clinical Standards as reported in the Clinical Documentation Audit Report' and aims to achieve '80% compliance all regions (average across each regions)' by 2021.

Accordingly, steps have been taken to give effect to Recommendation 8.

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2.9 Recommendation 9

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

2.9.1 Background

In the 2014 Investigation, the Office considered the legislative mandate of the Department of Communities, Child Protection and Family Support division, to promote the wellbeing of children and 'provide for the protection and care of children in circumstances where their parents have not given, or unlikely or unable to give, that protection and care', as set out in section 6 of the *Children and Community Services Act 2004*.

The Office also considered research literature which identified that:

- child maltreatment is a factor associated with suicide by children and young people;
- children and young people who have contact with statutory child protection authorities have a significantly increased risk of suicide;¹²
- children and young people can experience cumulative harm as a result of 'a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods';¹³
- in order to effectively identify and respond to cumulative harm, child protection and family services need to undertake well-informed, holistic assessments which respond to the chronic adversity faced by children and young people in a family, rather than treating each presentation to the service in an episodic or isolated manner and dealing only with the immediate safety issues for the child or young person in question; and
- an effective response to child maltreatment, including cumulative harm, is fundamental to reducing the risk of suicide by children and young people.

The 2014 Investigation also noted a number of practice risks and systemic barriers preventing effective recognition and responses to cumulative harm in the context of statutory child protection agencies:

¹² A Beutrais, P Ellis & D Smith, 'The risk of suicide among young in contact with Child, Youth and Family', *Social Work Now*, No. 19, 2001, p. 9.

¹³ R Miller, *Cumulative harm: a conceptual overview*, Victorian Government Department of Human Services, Melbourne 2007, viewed 20 September 2018, p. 1, <http://s7560c33f6eed0a65.jimcontent.com/download/version/1339119885/module/6097693077/name/ecec_best_intere_st_cumulative_harm.pdf>

Practice and systemic barriers to recognising and responding to cumulative harm:

Bromfield, Gillingham, and Higgins (2003) identified and summarised potential barriers to recognising and responding to cumulative harm, including both practice and systemic barriers. Practice risks include that:

- i) an event-oriented approach to Child Protection can result in practitioners failing to observe or be able to act in response to a pattern of maltreatment;
- ii) information is not carried over from one notification to the next and therefore information is lost over time;
- iii) assumptions are made that the problems presented in previous notifications are resolved at closure;
- iv) risk frameworks consider pattern and history with the aim of predicting future behaviour of carers and likelihood of harm rather than establishing the cumulative harm suffered; and
- v) IT systems summarise and categorise previous contact and workloads in Child Protection are demanding therefore the assumption is made that reading case files is neither necessary nor a priority.

Systemic barriers to recognizing and responding to cumulative harm:

- i) Child Protection being viewed and operated as an emergency service;
- ii) the system not recognising that families' problems can be ongoing;
- iii) harm thresholds mean that children considered as 'low risk' fall outside the legislative mandate;
- iv) a child has to be significantly harmed or at risk of significant harm; and the event is likely to happen again.¹⁴

The Office observed that policy and legislation in some other Australian jurisdictions incorporates specific provision for the identification, assessment and response to cumulative harm suffered by a child or young person. In Victoria, the *Children, Youth and Families Act 2005*, required that:

- 'in determining what decision to make or action to take in the best interests of the child, consideration must be given to ... the effects of cumulative patterns of harm on a child's safety and development ... where relevant to the decision or action' (section 10(3)(e)); and
- for the purposes of determining when a child is in need of protection 'the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances' (section 162(2)).

¹⁴ Miller R, *Cumulative harm: a conceptual overview*, Victorian Government Department of Human Services, Melbourne 2007, viewed 20 September 2018, <http://s7560c33f6eed0a65.jimcontent.com/download/version/1339119885/module/6097693077/name/ecec_best_interest_cumulative_harm.pdf>, p. 35.

Recommendation 9 was made on the basis of the above research, and the Office's findings that:

- 20 of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment;
- all of the 20 young people were known to the Department of Communities, Child Protection and Family Support division;
- 17 of the 20 young people in Group 1 were recorded as allegedly experiencing more than one form of child maltreatment, and therefore were likely to have suffered cumulative harm; and
- in Western Australia, there was no explicit legislative requirement for undertaking holistic assessments to recognise cumulative harm.

2.9.2 Department of Communities report

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 a range of information in:

- reports prepared by the Department of Communities; and
- meetings with the Department of Communities.

The Department of Communities relevantly informed the Office that:

The definition of harm in section 28(1) of the *Children and Community Services Act 2004* has been amended to include explicit recognition that a child 'in need of protection' may have been harmed by 'a single act, omission or circumstance' or a series or combination of acts, omissions or circumstances'.

The amendments to the definition of 'harm' in section 28 of the Act unambiguously provide that a child is in need of protection if the child suffers, or is likely to suffer, cumulative patterns of harm as a result of any of the things identified in section 28(2)(c) and (d) – for example physical, sexual or emotional abuse, and neglect.

Section 28(1) of the *Children and Community Services Act 2004* was amended by the *Children and Community Services Amendment and Repeal Act 2015*. The explanatory memorandum for this Act relevantly states that:

Clause 28. Section 28 amended

Clause 28 amends section 28, which deals with when a child is in need of protection. ... Subclause 28(2) amends the section 28(1) definition of "harm" in relation to a child, to mean "any detrimental effect of a significant nature on the child's wellbeing, whether caused by –

- (a) A single act, omission or circumstance; or
- (b) A series or combination of acts, omissions or circumstances;"

This amendment recognises the cumulative effects of harm caused by multiple types of abuse, or abuse over a period of time and is made in response to Recommendation 9 of the Ombudsman Western Australia report *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, April 2014.¹⁵

Accordingly, steps have been taken to give effect to Recommendation 9.

¹⁵ Western Australia, Parliament, *Explanatory Memorandum: Children and Community Services Legislation Amendment and Repeal Bill 2014*, Perth, 2014, p. 12.

2.10 Recommendation 10

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

2.10.1 Background

The 2014 Investigation identified that the effect of experiencing multiple forms of child maltreatment is referred to in the research literature as **cumulative harm**,¹⁶ as follows:

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

Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods.¹⁷

In the 2014 Investigation, the Office noted that, historically, the (then) Department for Child Protection and Family Support's intake, assessment and investigation processes were not holistic, and did not 'put together all the information available to the Department.'¹⁸ As identified in the 2008 *Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present (Group Analysis Report)* there was 'a tendency for caseworkers to overemphasise small improvements often without sighting the children and there was a very worrying absence of any assessment of the potential harms being done to children'¹⁹ arising from an episodic assessment approach, instead of a focus on cumulative harm. For these reasons, the Group Analysis Report recommended that the Department develop:

... a clear and specific procedure for undertaking a ... formal and documented child impact assessment of the risks associated with cumulative harm in cases where neglect is indicated – including a rigorous assessment of their current wellbeing and development as well as any associated risks to their continuing development.²⁰

Accordingly, the Office reviewed a number of policies and procedures of the (then) Department for Child Protection and Family Support to identify those which addressed the

¹⁶ Price-Robertson R et al, *Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma*, Australian Institute of Family Studies, Melbourne, 2013, citing Miller R and Bromfield L, 2010.

¹⁷ Miller R, *Cumulative harm: a conceptual overview*, Victorian Government Department of Human Services, Melbourne 2007, viewed 20 September 2018, <http://s7560c33f6eed0a65.jimcontent.com/download/version/1339119885/module/6097693077/name/ecec_best_interest_cumulative_harm.pdf>.

¹⁸ Ford P, *Review of the Department for Community Development: Review Report*, Government of Western Australia, Perth, 2007, p. 62.

¹⁹ Francis K et al, *Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present*, National Drug Research Institute, Perth, 2008, pp. ix-x.

²⁰ Francis K et al, *Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present*, National Drug Research Institute, Perth, 2008, p. 57.

need to undertake a holistic child impact assessment in order to appropriately recognise children and young people experiencing cumulative harm.

The Office found that some policies and procedures included references to cumulative harm, some included guidance incorporating cumulative harm concepts and associated practice requirements and others had no reference to cumulative harm, as summarised in the table below (Table 1).

Table 1: Findings of the 2014 Investigation, references to cumulative patterns of harm in relevant the (then) Department for Child Protection and Family Support policies and procedures

	Explicit reference to cumulative harm	Implicit reference to cumulative harm	No reference to cumulative harm
Policies	<i>Policy on Neglect (2012)</i>	<i>Signs of Safety Child Protection Practice Framework (2011)</i> <i>Standard 2 of Better Care, Better Services (2007)</i>	<i>Family and Domestic Violence Policy (2012)</i> <i>Policy on Child Sexual Abuse (2009)</i>
Procedures	<i>Casework Practice Manual Chapter 4.6: Neglect</i> <i>Casework Practice Manual Chapter 5.1: Safety and Wellbeing Assessment</i>	<i>Casework Practice Manual Chapter 4.1: Duty Interactions and Initial Inquiries</i>	<i>Casework Practice Manual Chapter 15.2: Responding to young people who express suicidal thoughts and behaviours and/or who are engaging in self harming behaviour</i>

2.10.2 Department of Communities report

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 a range of information in:

- reports prepared by the Department of Communities; and
- meetings with the Department of Communities.

The Department of Communities relevantly informed the Office that:

Case practice guidance relating to cumulative harm is regularly revised and strengthened as part of the Department's Casework Practice Manual (CPM) review cycle.

The following CPM revisions were made in the reporting period:

Chapter 1.2 of the CPM *Signs of Safety – The Department's Child Protection Framework* was updated [on 11 February 2014] to strength the consideration of the impact of past harms in assessment and safety planning.

A new related resource *Roadmap: Family Owned Safety Planning* was developed and added to assist in safety planning and building safety networks to protect children from future harm [on 11 February 2014].

Chapters 4 and 5 of the CPM were amalgamated into *Chapter 4: Assessing and Responding to Child Protection Concerns*. This streamlined and improved case practice guidance relevant to assessing and responding to harm arising from different types of abuse and neglect [updated October 2014].

Chapter 4.1 Assessment and Investigation Processes highlights the importance of keeping an updated chronology for assessment in high risk neglect cases and where a child has or is likely to suffer cumulative harm as a result of abuse. This chapter includes the related resource: *Background Paper: Assessing and Responding to Cumulative Harm, September 2012*.

The Department developed the *Policy on Assessment and Investigation Process* to guide practice requirements and provide consistency across districts when assessing and responding to allegations of abuse and neglect. The policy provides further clarity on the requirement to assess the impact on a child of physical, sexual, emotional and psychological abuse or neglect. The policy was added to Chapter 4.1 of the CPM Assessment and Investigation Process [on 22 October 2014]. ...

Chapter 14.1 of the CPM Mental Health Issues was reviewed and updated [on 3 July 2015] to include the potential for cumulative harm to occur as a result of a parent/s mental illness. The related resource *Impact of trauma, neglect and cumulative harm on children* was reviewed and added to this chapter. The review of this chapter included consultation with the Department's Aboriginal Engagement and Coordination Directorate (AECD), 12 June 2015.

Chapter 14.2 of the CPM Suicide and self-harm was revised to strengthen case worker's recognition and assessment of suicide concerns for children and young people in the care of the CEO or who may have come into contact with the Department. Given these children's life experiences and the potential for cumulative harm resulting from abuse and neglect they may be at an increased risk of suicide or self-harm. Review of this chapter included consultations with clinical psychologists of the Department (14 April and 5 May 2015), the AECD (19 March 2015) and the Department of Education (DoE) Suicide Prevention Team (24 March 2015). Information from the Mental Health Commission (MHC) strategy, *Suicide Prevention 2020: together we can save lives*, was utilised to inform the chapter review. ... the revised Chapter 14.2 of the CPM *Suicide and Self-harm* ... has now been approved and updated to the CPM [on 22 October 2014].

Chapter 5.1 of the CPM *Assessing Emotional Abuse – Family and Domestic Violence* provides duty interaction and case practice guidance on assessing for emotional abuse and the potential for cumulative harm where a child has been exposed to FDV [on 1 July 2016].

Chapter 5.2 of the CPM *Safety Planning Emotional Abuse – Family and Domestic Violence* has been reviewed and updated [on 30 June 2016] to strengthen case practice guidance in safety planning for emotional abuse resulting from FDV.

In 2016, the Department developed the resources; *Emotional Abuse Family and Domestic Violence: Safety Planning Toolkit* and *Emotional Abuse Family and*

Domestic Violence: Assessment Toolkit, which strengthen understanding of the potential for cumulative harm to occur as a result of FDV. The toolkits have been added to the related resources in Chapters 5.1 and 5.2 of the CPM.

To better respond to the complex and changing needs of children in care, the Department has developed the Needs Assessment Tool (NAT) [in 2016]. The NAT is a case-management tool that specifically identifies any self-harming or suicide behaviour and the mental health of a child over a 12 month period. The consistent capture of a child's safety and mental health over a period of time allows caseworkers to respond to any changing needs of the child and reduce the potential for cumulative harm to occur in the future. ...

Sexual Abuse Policy

Following on from the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission), the policy on child sexual abuse and the casework practice manual entry 2.2.4 child sexual abuse are currently under review.

The Royal Commission recommendations and the WA Government response to recommendations (June 2018) and policies and guidance from other jurisdictions have been reviewed. Consultations have commenced and it is anticipated that the policy and related casework practice manual entry will be finalised by the conclusion of the first quarter of 2019.

Accordingly, steps have been taken to give effect to Recommendation 10.

2.11 Recommendation 11

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

2.11.1 Background

Recommendation 11 was based on the findings of the Office in the 2014 Investigation that:

- all of the 17 young people in Group 1 who were likely to have suffered cumulative harm were known to the (then) Department for Child Protection and Family Support, many through multiple interactions. The Office examined whether, for these 17 young people, the (then) Department for Child Protection and Family Support considered the potential for cumulative harm to have occurred by undertaking holistic assessments.
- the three key stages of the (then) Department for Child Protection and Family Support's procedures are: duty interactions; initial inquiries [addressed in Recommendation 12]; and Safety and Wellbeing Assessments [addressed by Recommendation 12]. The Office examined the assessments undertaken by the (then) Department for Child Protection and Family Support staff at each of these three stages and found that in regard to duty interaction:
 - for the 17 young people who were recorded as having allegedly experienced more than one form of maltreatment, the (then) Department for Child Protection and Family Support received information that raised concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an assessment of this information; and
 - it was not possible to examine whether the (then) Department for Child Protection and Family Support assessed the potential for cumulative harm during the duty interaction process as information which would allow such an assessment to take place is not recorded by the (then) Department for Child Protection and Family Support.

2.11.2 Department of Communities report

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 a range of information in:

- reports prepared by the Department of Communities; and
- meetings with the Department of Communities.

The Department of Communities relevantly informed the Office that:

The Department has developed a range of learning opportunities, forums, mandatory training modules and professional development courses that strengthen field staff skills and compliance with case practice guidance.

All Department case workers are required to complete Orientation to Child Protection and Signs of Safety (Program One) and Orientation Simulated District (Program Two) within the first 12 months of appointment. These modules strengthen duty/intake workers knowledge and application of case practice guidance in the CPM.

The Department's Policy and Case Practice Units are redeveloping Program One (renamed Introduction to Child Protection) to include new course content and learning materials to strengthen case worker training in recognising and responding to child sexual abuse, physical neglect and the cumulative harm caused to children and young people as a result of these types of abuse.

Training includes the use of specific tools to assist with identifying patterns of harm impacting on a child or young person. The system tool 'chronology' was developed to create an individual history of a person's referrals and interactions with the Department. This enables a caseworker to recognise and respond to potential cumulative harm, through building a composite picture of the frequency, severity, source of harm and duration of abuse that a child or young person has experienced.

Compliance with case practice guidance, policies and procedures are also strengthened through the Department's Intake Team Leaders Group meetings (ITLG), which run for two hours and are held every six weeks. The ITLG provides a forum for discussion of case practice issues and improvements to the duty intake process.

District Structural Review

Phase 1 of this review work commenced in 2015 looking at a profile of each of the districts and how each district was structured. It also took into account numbers of children in care, staffing levels and resulted in a number of recommendations for the next phase of the work.

Phase 2 of the District Structural Review outlined 6 sub projects as outlined below;

1. District Structures and Processes
2. Centralised Intake
3. Specialised Roles
4. The Care Team Approach
5. Case Support Officers
6. Intensive Family Support

Overall, the outcome was that each district was to be structured similarly with all front end teams called Child Safety Teams, Intensive Family Support Teams being created to meet the aims of the Department's *Earlier Intervention and Family Support Strategy* and Care Teams being created to manage all the children in out of home care. This would result in members of the public as well as internal and external stakeholders experiencing greater consistency in the way the 17 districts across the state were structured and in the service delivery.

Out of the six projects, four have been fully implemented with Specialised Roles and Case Support Officers being the last two to be finalised. Capability Matrices that align with the Signs of Safety Reloaded project are in a pilot phase and this work is a deliverable from the Specialised Roles sub-project. The Case Support Officer sub-project (which is about the Department's use of para-professionals) is now being completed in partnership with the Union (CPSU).

This consistency in structure means that service delivery can be more targeted and implementation of new practice directions can be managed more strategically and efficiently.

CPM Review

In 2018, to further strengthen the efficacy of the CPM and to support staff compliance with the policies and procedures contained in it, Communities has contracted an independent review of the CPM to consider improvements to:

- Consistency of language
- Ease of navigation and searching
- Duplication of information is minimised
- Guidelines and structure enable clarity, and
- Practice guidance, procedures and tools are interconnected.

It is anticipated the final review report with findings, recommendations and next steps to progress the redevelopment of the CPM will be completed by the end of 2018.

Training to Strengthen Staff Competency and Compliance

As previously reported, Communities strengthens compliance with revised case practice guidance and policies relating to cumulative harm, suicide awareness and prevention through targeted training programs and forums.

Training

In addition to the Learning and Development Centre providing training for staff in Gatekeeper Suicide Prevention, specific training in suicide prevention for Aboriginal children and young people is being delivered through Indigenous Psychological Services Suicide Prevention in Aboriginal Communities (IPS). IPS is based on the research of Dr Tracy Westerman, an internationally recognised expert in Aboriginal mental health, cultural competency and Aboriginal suicide prevention.

It is now a requirement that all permanent clinical psychologists complete training in IPS within the first year of their appointment. In 2016-17, 15 clinical psychologists were trained in IPS and in 2017-18 a further 12 completed the training. There are another nine clinical psychologists scheduled to undertake the training in October 2018.

Workshop focussing on Suicide

On 27 July 2018, Therapeutic Care Services facilitated a child protection workshop with a specific focus on suicide awareness, response and prevention. The workshop was attended by 44 Communities clinical psychologists from all regions across the State and included representatives from Youth Justice. The workshop program included two key presentations:

- Demographic data and research around suicide – Catherine Rice, Clinical Psychologist, Communities
- Two hour presentation on dealing with a face to face suicidal client that included a powerful role play – Lifeline

Central Intake Model

Following a comprehensive internal review of how Child Protection work was being completed across WA, it was ascertained that a number of inconsistencies in child protection practice were evident between different geographical districts.

As a result of this review a number of recommendations were made with a view to improving the delivery of Child Protection services to the community. One of these recommendations was that the Department implement a Centralised Intake Model to become the first point of contact for reporting of child protection concerns for children to ensure decisions regarding the need for statutory child protection involvement be made to a consistent threshold of concern. This recommendation has seen the formation of the Central Intake Team (CIT) which became operational in July 2017.

In line with the Department's strategic outcomes of:

- Families and individuals are assisted to overcome their risks and crises, are kept safe and are diverted from the child protection system; and
- Children and young people needing protection are safe from abuse and harm

The Central Intake model has been developed to provide a consistent approach to managing work coming into the Department through strengthened professional relationships and service provision practices. This aims to achieve a reduction in the numbers of families, particularly Aboriginal families, requiring statutory intervention and overall provide improved access for all clients to earlier intervention and other support services in the community.

The Interaction Tool

The Central Intake Interaction Tool (the Tool) was introduced in 2017 and is used to assess all child protection contacts in the Perth metropolitan area, at the point of initial referral, to determine whether further action by Communities is required.

On 1 February 2019 ... Communities approved an independent evaluation of the Tool to be undertaken by the South Australian based Australian Centre for Child Protection (ACCP).

The project commenced on 28 October 2019 and will run for a period of 8 months resulting in a presentation to key stakeholders on key findings and recommendations followed by a draft and subsequently a final report.

The evaluation will focus on reviewing the application and appropriateness of the Tool. It will also consider whether the monitoring framework that is in place remains relevant and appropriate.

The evaluation approach includes;

- site visits to meet with staff, observe the application of the Tool and to interview staff who have applied the tool;
- selection and analysis of a variety of cases assessed used the Tool and
- review of the tool against appropriate and relevant legislative frameworks and legal definitions and of the monitoring framework

Communities will meet regularly with the expert research and clinical project team at ACCP, led by Professor Leah Bromfield and Professor Fiona Arney Co-Directors of ACCP, providing support, guidance and direction as required.

Continual Improvement

Since the Central Intake Team (CIT) has become operational, a number of ongoing structural changes and enhancements have been made. Coinciding with the launch of the CIT was the launch of the newly established Department of Communities as part of the wider Machinery of Government reforms occurring across the Public Sector.

This reform has brought together the former Departments of Child Protection and Family Support, Housing and Disability Services Commission to form the new Department of Communities. This has seen significant changes to the Department's structure and allowed opportunities for greater information sharing. Changes that have improved the effectiveness of the CIT, and the delivery of child protection and community services across WA include:

- Internal processes of the CIT for efficient and effective response to demand and workload being managed by the team.
- Expansion of the boundaries of the CIT to include the Peel District. This brings district boundaries of the former CPFS in line with other Departments merged to form the Department of Communities.
- Inclusion of the CIT within the newly formed State wide Referral and Response Service, bringing together the first point of contact with child protection for referrers who hold concerns for the safety of children.
- Inclusion of a Housing Officer within the CIT to improve information sharing at the point of referral between state provided community services leading to enhanced decision making.

Other additional steps taken by the Department are reviewing training programs being delivered by the Department's Learning and Development Centre with

a particular focus on Orientation Programs. Program Two in particular focusses on assessment.

Accordingly, steps are proposed to be taken to give effect to Recommendation 11.

However, as identified in Chapter 8.3 of Volume 3, the Office's further investigation into the lives of the 79 children and young people who died by suicide after the 2014 Investigation period has identified that:

- 39 of the 50 children and young people (78 per cent) in Group 1 who died after the 2014 Investigation allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm; and
- in 103 of the 658 interactions in which the Department of Communities received information alleging abuse, harm or neglect of a child or young person it was recorded as a 'family support', 'practical problem' or 'other crisis issue', rather than a 'child protection' concern.

Therefore, the Office will continue to monitor and report on the steps taken to give effect to Recommendation 11.

2.12 Recommendation 12

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

2.12.1 Background

As outlined in Chapter 2.11 of this volume, in the 2014 Investigation the Office identified that of the 20 young people in Group 1, 17 (85 per cent) were recorded as having allegedly experienced more than one form of child maltreatment. The Office found that in the key stages of initial inquiries and Safety and Wellbeing Assessments for 12 young people in Group 1:

- there were 27 instances of intake and initial inquiries. During these initial inquiries there was evidence that the (then) Department for Child Protection and Family Support assessed the potential for cumulative harm or progressed to a Safety and Wellbeing Assessment to enable this to be done, in 17 instances. the (then) Department for Child Protection and Family Support did not progress to a Safety and Wellbeing Assessment in two instances. In these two instances, the (then) Department for Child Protection and Family Support did not assess for the potential for cumulative harm; and
- there were 25 Safety and Wellbeing Assessments conducted. There was evidence that the (then) Department for Child Protection and Family Support assessed the potential for cumulative harm in two Safety and Wellbeing Assessments.

2.12.2 Department of Communities report

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 a range of information in:

- reports prepared by the Department of Communities; and
- meetings with the Department of Communities.

The Department of Communities relevantly informed the Office that:

The Department strengthened compliance with revised case practice guidance and policies relating to issues of cumulative harm through the following mandatory training programs in 2014-15:

Assessing Child Abuse and Neglect Using Signs of Safety was delivered to 216 case workers. The course was delivered ten times over a 12 month period, in metropolitan and regional locations.

Impact of Trauma training was delivered to 328 child protection workers. The course was delivered 17 times over a 12 month period across metropolitan and regional locations.

Impact of Trauma training was delivered to 83 residential care program workers. The course was run four times during the year at the Department's metropolitan training centre.

The revised Introduction to Child Protection (Program One) will be a requirement for all case workers in child protection, duty/intake, assessment, children in care and child centred family support. This will strengthen front line staff's knowledge of case practice guidance and their capacity to identify and respond to the emotional and psychological impacts of cumulative harm caused by a range of abuse types.

Compliance with case practice guidance relating to the impacts of cumulative harm is also strengthened through Senior Practice Development Officer (SPDO) meetings. The meetings run for a full day every six weeks, and provide a forum to discuss case practice issues. At the 1 July 2015 meeting, a presentation 'Cumulative Risk, Cumulative Impact or Cumulative Harm?' was delivered at the Signs of Safety "Digging Deeper into Practice" session".

On 3 February 2017, the Department provided a second report to the Office, which stated that:

As advised in the previous report, the Department strengthens compliance with revised case practice guidance and policies relating to issues of cumulative harm through mandatory training programs. The following is an update of staff training for 1 August 2015 to 31 December 2016.

Assessing Child Abuse and Neglect Using Signs of Safety was delivered four times to 46 district office staff.

Impact of Trauma on Children and Youth was delivered 18 times in regional metropolitan locations to 122 Residential Care and Secure Care officers and 48 district case workers.

The NAT is a compulsory practice requirement and is embedded in Assist, the Department's case management system. NAT training and information sessions were delivered to all district office staff in November and December 2016. Senior Practice Development Officers (SPDOs) will provide implementation support to districts until February 2017, and future training will be provided by the Department's Learning and Development Centre.

To strengthen staff compliance with new FDV resources, the Department is developing a two day pilot training program: *Emotional Abuse FDV for current field workers*. Training will be delivered in February 2017, and at the completion of the pilot the program will be mandatory for all new field staff.

Upon request for additional information, the Department informed the Office that:

Intensive Family Support Teams (IFS) have been established in each district across the state. IFS Teams use multidisciplinary case consultation forms where other specialist staff, both internal and external professionals can discuss specific children. Part of the MCC form includes scoring the Adverse Childhood Experiences (ACE score) a child has experienced since birth. The ACE score is an internationally recognised screening tool to assist in the future case planning of a child and help build resilience around the child, their family and their community. It is also a way of understanding the cumulative harm a child may

have experienced. The IFS monitoring framework was commenced in February 2017. The Framework reports on how well implementation of this way of working is progressing. The results indicate that MCCs and the general work of IFS teams is being well implemented across the state.

Multidisciplinary Case Consultations (MCC)

This process commenced in February 2017 with its primary use being in Intensive Family Support Teams. The MCC was based on the Formulation Exercise that is a tool within the Family Finding Approach. It is a child focused series of questions that draws on the expertise of professionals involved with a child to better help inform an integrated case management approach as well as a trauma informed approach to the child and their family. A key aspect of the MCC is the scoring of the Adverse Childhood Experiences (ACE Score) that the child has experienced. This is an internationally recognised way of understanding the trauma a child has experienced as well as looking at a 5 year trajectory for the child if their circumstances don't improve. These multidisciplinary discussions have been informative for all professionals involved in the case.

An evaluation of this way of working continues through the Intensive Family Support Monitoring Framework.

SWA Project

The purpose of the Safety and Wellbeing Assessment (SWA) Project was to promote better critical thinking and documented analysis of information concerning allegations of abuse and/or neglect, including improving quality assurance processes.

The decisions of the SWA Project were endorsed by Service Delivery Joint Executive Team in December 2018.

As of 1 July 2019, Safety and Wellbeing Assessments are now referred to as Child Safety Investigations (CSI). The change aligns with language in the Children and Community Services Act 2004 and brings a sense of urgency to the work.

All changes to the way Communities respond to and investigate abuse and neglect commenced on 1 July 2019.

In April 2019 Communities commenced the implementation phase of the project as follows:

- Between April 2019 – July 2019, the Professional Practice Unit (PPU) has trained more than 1200 Communities staff in District Offices across the State in CSI processes. This has included all regional, remote and metropolitan district offices; State-Wide Referral and Response; staff from other business units such as the General Law Unit, Duty of Care Unit, Professional Practice Unit, Learning and Development, and Policy and Service Design Unit.

On 1 July 2019, Communities launched the new practice guidance and changes to recording.

Ongoing practice sessions have been established via CSI Clinics over August 2019 – 2020.

The Child Safety Investigation training has been embedded in core Orientation Programs delivered by Learning and Development to support the professional development of new staff.

Accordingly, steps are proposed to be taken to give effect to Recommendation 12.

However, as identified in Chapter 8.3 of Volume 3, the Office's further investigation into the lives of the 79 children and young people who died by suicide after the 2014 Investigation period has identified that the high proportion of 'family support' interactions which the Office identified as containing information relating to signs of neglect or emotional abuse as defined in the Department of Communities' policy publications (86 of the total 118 family support interactions, 73 per cent) may indicate that staff compliance with policies and procedures which require them to assess the potential for cumulative harm could be further strengthened.

Accordingly, the Office will continue to monitor and report on the steps taken to give effect to Recommendation 12.

2.13 Recommendation 13

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

2.13.1 Background

In the 2014 Investigation, the Office found that:

- of the 20 young people in Group 1, Aboriginal young people had higher levels of contact with the (then) Department for Child Protection and Family Support than non-Aboriginal young people, as follows:
 - of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, nine were Aboriginal and eight were non-Aboriginal;
 - 198 (77 per cent) duty interactions for the young people in Group 1 concerned Aboriginal young people; and
 - of the 12 young people in Group 1 who were the subject of initial inquiries or a Safety and Wellbeing Assessment, seven were Aboriginal and five were non-Aboriginal.
- the (then) Department for Child Protection and Family Support currently engages as a specialist position, Aboriginal Practice Leaders to assist with matters relating to Aboriginal young people. The Case Work Practice Manual sets out specific requirements when the Aboriginal Practice Leader should be consulted. However, this requirement for consultation is generally limited to interactions involving children in the care of the Chief Executive Officer.
- the findings of this investigation indicate that it is also important that Aboriginal Practice Leaders are consulted when the potential for cumulative harm is being assessed for Aboriginal young people, to ensure responses to this are culturally appropriate.

2.13.2 Department of Communities report

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 a range of information in:

- reports prepared by the Department of Communities; and
- meetings with the Department of Communities.

The Department of Communities relevantly informed the Office that:

Departmental policy requires that child protection workers must consult with Aboriginal Practice Leaders (APLs) or a suitable Aboriginal officer when a child is being taken into care, for child placement arrangements (including permanency planning or reunification), or when a case plan is being developed for an Aboriginal child in the care of the CEO.

This policy operationalises provisions in the *Children and Community Services Act 2004* (Section 12 Aboriginal and Torres Strait Islander child placement principle and Section 81 Consultation before placement of Aboriginal and Torres Strait Island[er] child).

The principle of strengthening the role of APLs in case practice guidance where there is the potential for cumulative harm has been further expanded across the CPM as follows:

Chapter 10.1 of the CPM *Permanency Planning* was updated to include the related resource *Permanency Planning: Identity and Long Term Stability*, which outlines the process and consultation points when APLs or a suitable Aboriginal officer must be consulted when assessing long term out-of-home care options for Aboriginal Children.

Chapter 14.1 of the CPM *Mental Health Issues* was updated to include the requirement to consult with APLs or an officer of the Aboriginal Engagement and Consultation Directorate (AECD) when Aboriginal children or young people are involved.

The *Remote Services Framework 2014* was added to this chapter. This provides the linkage between Senior Community Child Protection Workers – Remote (SCCPW-R) working in remote Aboriginal communities with APLs and the AECD for cultural advice and consultation.

Chapter 14.2 of the CPM *Suicide and Self-harm* has been revised and proposed amendments include the requirement for case workers to consult with APLs or the AECD when Aboriginal children or young people are involved.

The Department supports and promotes a strong leadership role for APLs in the districts in which they work. To achieve this it has developed the *Aboriginal Practice Leaders Directions Paper 2015*, which contains a number of recommendations to further enhance the role of APLs in case practice guidance and care planning to improve outcomes for Aboriginal children.

The Department recognises that there are additional factors which impact on the wellbeing of Aboriginal children and young people. APLs and the AECD take a holistic approach to identifying and assessing patterns of harm that impact on Aboriginal children and families, cultural and spiritual concerns and legacy issues resulting from historical events and practices.

On 3 February 2017, the Department provided a second report to the Office, which stated that:

As advised in the previous response, relevant CPM chapters have been updated to require case workers to consult with Aboriginal Practice Leaders (APL) when Aboriginal children or young people are involved.

In 2016 the Department developed the Care Team Approach Practice Framework, whereby every child in care has a 'care team' comprised of people important to the child.

The care team supports a child's care arrangements, their continued connection to parents, siblings, wider family, networks, culture and healing from trauma.

APLs must be consulted when identifying care team members for an Aboriginal child or when the majority of care team members should be Aboriginal.

The Department has developed the Aboriginal Services and Practice Framework 2016-2018 (ASF), which underpins the review, development and implementation of all services, policies and practices when working with Aboriginal children, families and communities. As part of the framework, APLs have a key role in providing advice on culturally safe and responsive case practice in the Department's work with Aboriginal children and families.

Following a request for additional information, the Department of Communities informed the Office that:

Department of Communities (Communities) Casework Practice Manual Related Resource Suicide and Aboriginal people outlines that loss, grief, trauma and bereavement are experienced more collectively in Aboriginal communities than the wider community, and the aftermath of suicide stress can impact on a community's ability to cope and contain suicidal behaviour, increasing the risks of clusters of suicides occurring. The resource outlines the cumulative impact of violence, sexual assault and family conflict, which are all risk factors for suicide in Aboriginal people.

The Department's Central Intake Team (in the metropolitan area) commenced on the 1 July 2017 and has a designated Aboriginal Practice Leader (APL). The services focus on the 'front end' continuum of child protection and undertake a range of activities at duty interaction and initial inquiry. The APL is regularly involved in consultations for Aboriginal children, young people and families in contact with child protection services.

When a case is referred to an Intensive Family Support (IFS) team, an initial multidisciplinary case consultation (MCC) must be held within 30 days, to determine the direction of the case. MCCs are targeted consultations attended by relevant specialist staff which may include Team Leaders, Child Protection Workers, Aboriginal Practice Leaders, Psychologists, Senior Practice Development Officers, Family and Domestic Violence Workers, Education Officers, and Legal Support Officers. Initially the MCC will be used to determine the best differentiated response for a family that presents with multiple concerns to the department based on danger statements and safety goals. MCCs also provide a mechanism for reviewing IFS cases every 30 days.

Entries in the Casework Practice Manual (CPM) include practice requirements for consultation and advice to be provided by district Aboriginal Practice Leader or other relevant Aboriginal officers for assistance in developing an effective client engagement, assessment, and a case management plan that takes into consideration cultural issues. ...

Section 2.2.4 Conducting a Child Safety Investigation includes a sub-section guiding culturally responsive practice. This includes a duty to consult with an Aboriginal Practice Leader and/or local cultural advisor as soon as possible to gather information to assist in engaging with parents. There is also a section on the relationship between abuse and harm, and those which are considered cumulative in nature.

Accordingly, steps have been taken and are proposed to be taken to give effect to Recommendation 13.

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2.14 Recommendation 14

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

2.14.1 Background

In the 2014 Investigation, the Office noted that 17 of the 20 (85 per cent) young people in Group 1 were likely to have suffered cumulative harm, and had multiple interactions with the Department of Communities, Child Protection and Family Support division. Accordingly, the Office recommended that the Department use the information and data it has about children who have suffered cumulative harm to identify children and young people with unmet care and family support needs, who may be at risk of suicide.

2.14.2 Department of Communities report

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 a range of information in:

- reports prepared by the Department of Communities; and
- meetings with the Department of Communities.

The Department of Communities relevantly informed the Office that:

The Department participates in the Interagency Executive Committee which has oversight of the collection of agency data on children and young people with a combination of risk factors/indicators identified by the Ombudsman's report. This data will be used to identify a group of children and young people considered most at risk of suicide. A shared screening tool and joint case management approach will then be developed to target interventions for this group of children.

As part of this process, the Department has contributed to the identification of an 'at risk group', providing the Mental Health Commission (MHC) with information on the numbers of children aged 12-18 years who had a safety and wellbeing assessment (SWA) in the past 12 months and those who also had a previous or substantiated SWA.

The MHC is investigating ways to refine inter-agency data to identify a priority 'at greatest risk' group. The MHC and the Department will undertake further work as part of this process, and findings will be utilise[d] to further improve policy and practice guidance to respond to young people who have experienced cumulative harm.

The Department works collaboratively with DoE to cross-match quarterly data on children in care with the Students [whose] Whereabouts [is] Unknown List. DoE raise the list at local child safety group meetings attended by the Department.

An additional report provided by the Department of Communities on 3 February 2017 stated:

The Department continues to participate in the Interagency Executive Committee and to work with the Mental Health Commission in its task of identifying a priority 'at greatest risk' group.

The Department continues to work collaboratively with the Department of Education (DoE) to cross-match quarterly data on children in care with the Students Whereabouts Unknown List. Department data for cross-matching with DoE was provided:

- 21 August 2015
- 26 November 2015
- 3 March 2016
- 7 June 2016
- 29 August 2016
- 2 November 2016

In response to a request for further information, the Department of Communities informed the Office that:

Communities continues to work collaboratively with the Department of Education to cross-match quarterly data on children in care with the Students Whereabouts Unknown List. Data for cross-matching was provided on the following dates:

- 13 March 2017;
- 7 June 2017;
- 4 December 2017; and
- 5 June 2018.

Communities uses the Viewpoint program as an important tool in gathering unmediated information from children and young people in care about their views, worries and issues of concern. Viewpoint comprises a suite of age/capacity-related self-interviewing questionnaires, which must be offered to all children and young people in care as the first step in developing their individual care plans or at reviews. Questionnaires are delivered to children and young people on contemporary electronic devices for completion independently or with facilitation as required, and followed up by face-to-face discussion with their case worker to explore their responses in more depth. As a self-assessment tool, Viewpoint is effective in encouraging the disclosure of sensitive information, which allows child protection workers to better identify issues and provide targeted and timely support to improve outcomes for children in care.

The Viewpoint questionnaire captures information over a wide range of dimensions, including responses to safety and bullying, and for an older age group, self-harm and suicidal thoughts. Where risk is indicated, districts are required to provide an urgent response in accordance with the Casework Practice Manual, and an additional State-wide system delivers alerts to senior staff in districts to ensure urgent services are provided.

Under a Memorandum of Understanding (MOU) with the Commissioner for Children and Young People (CCYP), Communities provides a Viewpoint report on issues identified by young people to the Children's Commissioner on a six monthly basis.

Kimberley Children and Young People At Risk Meetings have been in place for a number of years. In February 2018, District Leadership Groups (DLGs) were established as a mechanism to work collaboratively across the human services sector to deliver responsive, integrated and effective services that improve the wellbeing of Kimberley children, families and young people.

A new structure for the Children and Young People At Risk Meetings has now been developed that includes a referral form/case management plan that is dedicated to each individual. This will enable actions to be clearly articulated and agreed upon and for updates including clear reasons for exit to be tracked.

Mental Health Commission

The following provides information on Communities work with the Mental Health Commission's Interagency Executive Committee and the development of an 'at greatest risk' screening tool and joint case management approach (Recommendation 22).

Background

In 2014, in response to Recommendation 22 (R22) of the OWA report, the Mental Health Commission convened the Interagency Executive Committee (IEC) to investigate ways to develop an across-agency screening tool to estimate the numbers of children and young people with a combination of risk factors/indicators identified in the OWA report. This cohort of children are considered to be at the highest end of the at risk category.

IEC membership at this time included: the Departments of Housing, Aboriginal Affairs, Education, Child Protection and Family Support; the Child and Adolescent Mental Health Service; and the WA Drug and Alcohol Office.

Members from the Departments of Education, Health and CPFS were requested to provide data on the number of children and young people (12 to 18 years) with indicators identified in the OWA report, ie: numbers on the suspension roll, those with absenteeism greater than 60 per cent or on the whereabouts unknown list and children and young people with more than one safety and wellbeing assessment (SWA).

On 13 April 2015 CPFS provided the following non-identified data to the MHC:

- Numbers of children aged 12-18 years who had a SWA in the past 12 months and those who also had a previous or substantiated SWA.

The CPFS representative attended all scheduled meetings.

On 10 November 2017, the MHC called a meeting to workshop the progression of work under R22. The primary purpose of the meeting was to establish each agency's understanding of R22, the purpose of the screening tool and proposed joint case management approach, along with protocols and policies within each agency to identify whether any could be leveraged to address the recommendation.

Current Situation

Following the 10 November 2017 workshop, the MHC were to hold a follow up meeting in either late 2017 or early 2018. Due to scheduling issues this did not occur, and the MHC advises that it plans to reconvene a meeting of the IEC in the near future.

Communities will continue to work with the MHC in the development of the screening tool and participate in the next meeting of the IEC.

Accordingly, steps have been taken and are proposed to be taken to give effect to Recommendation 14.

2.15 Recommendation 15

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

2.15.1 Background

The 2014 Investigation considered research literature:

- identifying that educational institutions and education professionals are in a unique position to identify and prevent suicide by young people by virtue of their ability to continually observe important indicators of mood such as academic performance, behaviour, interpersonal relationships and the ability to cope;
- associating failure/drop-out of school by young people with parent-child conflict and stressors relating to family functioning, which in turn are highly predictive of suicide risk for young people; and
- identifying that children and young people with a history of child maltreatment or trauma may have difficulties in learning and interacting in socially appropriate ways and regulating strong emotions (which may result in conflict with other students and teachers).

The Office relevantly found that:

- 18 of the 20 young people in Group 1 were recorded as having allegedly experienced child maltreatment and attended government schools and the opportunities for government schools 'to provide the protective factors that will assist in reducing the risk of suicide by these young people as they are in the process of being identified [as at risk of suicide], referred for treatment by and after discharge from mental health services';
- 19 of the 20 young people in Group 1 were enrolled at school at the time of their death (17 enrolled at a government high school and two enrolled at a non-government high school);
- during the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60 per cent of the time;
- of the 14 young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance; and
- the names of two young people who died by suicide were on the list of students whose whereabouts were unknown in the year before their death.

2.15.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that:

- *Student Attendance* policy was reviewed and clarified.
- Related policy guidelines and procedures were reviewed and clarified.
- The Department's website related to attendance was reviewed to improve access for users to information regarding policy, guidelines and procedures for both school staff and parents. Policy information and supporting resources were updated and published on the *Student Attendance* website. Additional resources have been made available through the establishment of a *Connect* e-community.
- Training was provided to assist regional staff (including members of the School Psychology Service and other complementary services) on the implementation and compliance of the revised *Student Attendance* policy.
- Materials were developed to support regional staff in the provision of training on the implementation of the revised policy to networks and schools. Resources are embedded within *Student Attendance* website.
- The Department undertook an internal audit of compliance with attendance policy.
- The Department has developed a strategic focus on the increased use of measures available in relevant legislation to manage attendance, such as attendance panels and responsible parenting agreements. A train the trainer program is in place and associated resource package has been developed. RPA [Responsible Parenting Agreement] guidelines have been developed (at this time Education is the only agency to have developed such guidelines).
- The Department's web site is under review. The new Ikon intranet provides a more targeted service for schools. It has yet to be decided where the information for parents from the previous website will be housed.
- The Department has since undertaken an independent evaluation of Attendance Panels and Badged Attendance Officers.
- A major review of the *Student Attendance in Public Schools* policy and procedures is underway.
- The School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury are currently being further updated in consultation with relevant stakeholders.

Accordingly, steps have been taken to give effect to Recommendation 15.

However, as outlined in Chapter 8.4 of Volume 3, the Office's further analysis of school attendance data for the children and young people who died since the 2014 Investigation period obtained during the course of child death reviews indicates that some children and young people who died by suicide continue to experience persistent school non-attendance in the year prior to their death.

The Office obtained school attendance records from the Department of Education for the 50 children and young people in Group 1 that died by suicide after the 2014 Investigation period:

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

For those 38 children and young people enrolled at a public school during the last year of their life, their attendance during that last year ranged from 0 to 98.7 per cent. However, of those 38 children and young people, 23 (61 per cent) were not regularly attending school and were at 'severe educational risk' under the Department of Education's *Managing Student Attendance in Western Australian Public Schools* policy, as follows:

- two (5 per cent) effectively did not attend school or the relevant registered training organisation in the last year of their life;
- 21 (57 per cent) attended school less than 60 per cent of time in the last year of their life;
- six (16 per cent) attended between 60 and 69 per cent of the time in the last year of their life;
- seven (18 per cent) attended between 70 and 89 per cent of the time in the last year of their life; and
- two (5 per cent) attended more than 90 per cent of the time in the last year of their life.

Accordingly, the Office will continue to monitor, and report on, the steps taken to give effect to Recommendation 15.

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2.16 Recommendation 16

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

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

2.16.1 Background

As identified at Chapter 2.15.1 of this volume, the 2014 Investigation identified that 19 of the 20 young people had allegedly experienced child maltreatment and were enrolled in school at the time of their death. The Office also found that 14 of these 19 young people attended less than 60 per cent of the time.

2.16.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that:

Consideration was given to reference to cumulative harm in *Student Attendance* policy. The Corporate Executive approved policy provides a more general statement about assessment of risk of harm.

Consideration was given to reference cumulative harm in procedures and guidance for the *Student Attendance* policy. The Department has revised guidance associated with the *Student Attendance* policy to provide explicit reference to giving consideration to risk of harm in the application of attendance policy.

The Department and DCPFS have improved shared strategies to address persistent absence issues. By mutual agreement between the respective Directors General, referral by Education to DCPFS is now a mandated pathway in addressing persistent disengagement.

The Department continues to cultivate local, regional-based interagency partnerships to identify and coordinate responses to students at risk. This is managed in schools and regions.

The Department is currently addressing recommendations from the Public Accounts Committee's report, *Setting the stage for improvement: Department of Education's management of student attendance 2018*.

A major review of the *Student Attendance in Public Schools* policy and procedures is underway.

The Department of Education's *School Attendance Procedures* now state that:

The principal should consider whether the persistent absence place the child or young person at suspected risk of harm and/or what other elements of risk to the student's wellbeing may be indicated by persistent absence from school.

In addition, on 5 May 2015, the Department of Education introduced the *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-injury (Guidelines)*. These Guidelines set out specific information about identifying, recognising and responding to children and young people at risk of suicide and non-suicidal self harm who attend public, Catholic or Independent schools.

Although the Guidelines do not expressly state that students attend school less than 60 per cent of the time may have suffered cumulative harm and/or be at heightened risk of suicide, it does identify that 'common indicators of concern' include:

- changes in activity and mood
- poor emotional regulation
- history of trauma
- decrease in academic performance
- difficulty concentrating and/or making decisions ...
- significant tiredness and/or loss of energy ...
- alcohol and/or other drug use
- peer conflict or withdrawal
- risk-taking behaviours
- persistent or sudden absence from school²¹

The Guidelines also set out additional considerations for schools in relation to children exposed to cumulative harm, as follows:

Schools exist in a range of contexts with students engaging in many different activities on and off the school site throughout the day. The specific needs of a young person at risk of suicidal behaviour and non-suicidal self-injury (NSSI) must be considered within an understanding of their unique environment and individual difference when responding to and planning for cases of suicidal behaviour and NSSI. Following are some additional considerations for schools:

...

²¹ Government of Western Australia Department of Education, *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-injury*, Department of Education, Perth, 2017, viewed 9 September 2018, p. 2, <http://det.wa.edu.au/policies/detcms/cms-service/download/asset/?asset_id=19838833>.

1.11.5 Children exposed to cumulative harm

- Understand that trauma, especially early childhood trauma, and harm accumulate risk in children for future mental ill health and suicidal ideation and behaviours, and NSSI.
- Understand that those children who have been exposed to trauma previously in their lives may require special consideration in risk management planning as they may become distressed and unable to regulate their emotions more readily, or present their distress differently.
- Identify, through trauma informed practice, the difference in response to triggers or stressors in the environment and time it takes to regulate emotions for young people exposed to trauma and take this into account when establishing a Risk Management Plan (RMP).²²

The steps to be taken after 'any suspicion or evidence of suicidal behaviour or NSSI [non-suicidal self injury]' are also provided in the Guidelines, including provision for:

- Risk assessments conducted by trained professional in circumstances where a staff member has a suspicion or evidence of suicidal behaviour;
- Specific procedures for responding to student disclosures of suicidal behaviour or self-harm;
- Locating a student and keeping them safe in circumstances where a disclosure indicates that the student is at imminent risk;
- Consultation with other staff, including specialist staff with knowledge in the area of suicide risk assessment, or consultation with CAMHS;
- Contacting parents/guardians and providing recommendations for further external assessment and contact details for emergency response services;
- Liaison with the Department of Communities, Child Protection and Family Support in circumstances where parents/guardians are not contactable or providing only limited support for the ongoing monitoring of the child;
- Informing other external service providers working with the child if there is an incident or disclosure at school; and
- Developing and regularly reviewing a risk management plan (RMP) with other school staff, the student, family and external agencies to manage the safety of the student when they are at school.²³

Accordingly, steps have been taken to give effect to Recommendation 16.

²² Government of Western Australia Department of Education, *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-injury*, Department of Education, Perth, 2017, viewed 9 September 2018, p. 9-11 <http://det.wa.edu.au/policies/detcms/cms-service/download/asset/?asset_id=19838833>.

²³ Government of Western Australia Department of Education, *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-injury*, Department of Education, Perth, 2017, viewed 9 September 2018, <http://det.wa.edu.au/policies/detcms/cms-service/download/asset/?asset_id=19838833>.

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2.17 Recommendation 17

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

2.17.1 Background

In the 2014 Investigation, the Office considered:

- section 89 and 90(1) of the *School Education Act 1999* and regulation 43(1)(a) of the *School Education Regulations* relating to school suspensions;
- sections 91 - 93 of the *School Education Act 1999* in relation to exclusions from school; and
- the Department of Education's policies regarding student behaviour, in particular:
 - Behaviour Management in Schools; and
 - Managing Student Behaviour.

The Office relevantly found, from our analysis of the 36 young people, that:

- ten of the 19 young people in Group 1 enrolled at school had been suspended from school;
- five of the 19 young people in Group 1 enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year; and
- a range of actions were taken when young people had been suspended for more than 10 days, however, the relevant policies were not consistently applied.

2.17.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that:

Behaviour Management in Schools and a number of associated policies were reviewed, clarified and consolidated into a single *Student Behaviour* policy and procedures.

Related policy guidance was reviewed and clarified.

Training was provided to assist regional staff (including members of the School Psychology Service and other complementary services) on the revised *Student Behaviour* policy. The training materials were then made available to these staff to assist in local promulgation of the new policy.

Following a request for clarification, the Department reported to the Office that:

[it] does not systemically monitor compliance with the *Student Behaviour* policy. Limitations in the Student Information System have restricted development of data to measure compliance.

Initial training was provided to regions in early 2016 to regional staff in all regions immediately following the publication of the Student Behaviour Policy.

In March 2016 *Requirements related to the Student Behaviour* policy were published on the Department's intranet. The requirements provide procedures to assist with implementation of a range of functions in student behaviour, including:

- Withdrawal of a student from classes, breaks of other school activities
- Suspension of a student from attending school
- Detention of a student after school
- Exclusion of a student from attending school
- Physical restraint of a student
- Protective isolation of a student for purposes of managing risk of harm
- Weapons in schools
- Personal use of mobile electronic [devices]
- Breaches of discipline suspected of being intoxicated
- Behaviour and Attendance
- Behaviour and disability

The Requirements related to the *Student Behaviour* policy have been viewed a total of 8,371 times between the 1 February 2016 and 16 August 2017.

Principals are responsible for implementation of the policy.

The Department monitors the Online Incident Notification System (The system for enabling schools and regional education offices to formally record and advise the Department of emergencies, critical incidents at other specific incidents) for risk mitigation and possible anomalies in relation to the student behaviour.

The Department provides a range of reports to relevant line managers such as School of Special Educational Needs: Behaviour and Engagement staff with relevant suspension data summaries that helps to inform their awareness of students who have accrued numerous suspension, and schools and regions where the number of suspensions has increased and may require additional support.

On 9 September 2019 the Director General announced that implementation of [the previously commissioned new student information system] webSIS is not progressing further at this stage. The Department's intention remains to explore additional solutions to the recommendation once replacement software for Integris [the existing student information system] has been released.

The *Student Behaviour in Public Schools* policy and procedures are scheduled for major review commencing 2020.

The *Requirements related to the student behaviour in public schools policy* is being rehoused to sit alongside the policy and procedures. This will improve ease of access for users.

Accordingly, steps have been proposed to be taken to give effect to Recommendation 17.

However, as outlined in section 8.4 of Volume 3, the Office's further analysis of student behaviour data for the children and young people who died since the 2014 Investigation period obtained during the course of child death reviews identified that compliance with the Department of Education's *Student Behaviour* policy continues to be an issue experienced in relation to some of the children and young people who died by suicide.

Accordingly, the Office will continue to monitor, and report on, the steps taken to give effect to Recommendation 17.

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2.18 Recommendation 18

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

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

2.18.1 Background

As discussed in relation to Recommendation 17, in the 2014 Investigation, the Office found that:

- ten of 19 young people in Group 1 enrolled at school had been suspended from school;
- five of 19 young people in Group 1 enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year; and
- a range of actions were taken when young people had been suspended for more than 10 days, however, the relevant policies were not consistently applied.

2.18.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that its:

Behaviour Management in Schools policy was reviewed to determine the inclusion of a reference, where appropriate to cumulative harm. An explicit reference to considering risks associated with cumulative harm was added. All schools are now required to document planned measures for addressing risks of suicidal behaviour and non-suicidal self-injury, including risks associated with cumulative harm from child maltreatment, as part of a whole school behaviour support plan.

The Department revised policy Guidance to provide further information and include procedures for giving consideration to risk of suicide, including risks associated with cumulative harm.

A new model of service for students and schools was implemented from the commencement of 2016. Through a new School of Special Educational Needs: Behaviour and Engagement, this model features improved coordination with other State government departments and authorities for students who demonstrate complex and/or elevated behaviour support needs or who are chronically disengaged.

The Department of Education's report also cited its Annual Report 2015-16 as evidence of the steps taken to implement Recommendation 18 in relation to its new School of Special Educational Needs, which states that:

The new model for supporting our most at-risk students, announced in May 2015, commenced in 2016 through 13 Engagement Centres across all regions and the Midland Learning Academy pilot. The new services, as well as Classroom Management Strategies and Positive Behaviour Support programs, were coordinated through the newly established School of Special Educational needs: Behaviour and Engagement. The Midland Learning Academy offered a trial model of alternative education provision for the most disengaged students.²⁴

In a further report to the Office, the Department of Education advised the Office that:

The Midland Learning Academy continues to operate.

The *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury* have been updated and are currently being further updated in consultation with relevant stakeholders.

As discussed in the Department of Education's report regarding Recommendation 17, its *Behaviour Management Policy* and other related policies were replaced by the new *Student Behaviour Policy* and *Student Behaviour Procedures* which commenced into effect on 4 January 2016 and 26 April 2016, respectively. The *Student Behaviour Procedures* relevantly state that:

The principal will document a whole school plan to support positive student behaviour that includes: ...

- the roles and responsibilities of staff in implementing whole school behaviour support;
- teaching and classroom management strategies that support positive student behaviour including:
 - the management of the school environment to promote positive student behaviour;
 - the school's strategy for communicating to parents on students' behaviour;
 - the school's strategy for deciding on the application of disciplinary measures;
 - the school's approach to coordinating with external agencies where required;
 - measures to address:
 - all forms of bullying;
 - aggression;

²⁴ Department of Education, *Annual Report 2015-16*, Department of Education, Perth, 2016, p. 35, viewed 9 September 2018, <<https://www.education.wa.edu.au/annual-report-2015-2016>>.

- drug and alcohol misuse by students, including provision of evidence-based drug and alcohol education;
- the presence of weapons on school sites;
- risks of suicidal behaviour and/or non-suicidal self-injury, including risks associated with cumulative harm from child maltreatment; ...²⁵

More specific information about identifying, recognising and responding to children and young people at risk of suicide and non-suicidal self-harm is set out in the Department of Education's *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-injury*, previously set out in relation to Recommendation 16. Although these Guidelines do not expressly state that students who have been suspended or excluded from school on multiple occasions may have suffered cumulative harm and/or be at heightened risk of suicide, it does identify that 'common indicators of concern' include:

- changes in activity and mood
- poor emotional regulation
- history of trauma
- decrease in academic performance
- difficulty concentrating and/or making decisions ...
- significant tiredness and/or loss of energy ...
- alcohol and/or other drug use
- peer conflict or withdrawal
- risk-taking behaviours
- persistent or sudden absence from school²⁶

The Guidelines also set out additional considerations for schools in relation to children exposed to cumulative harm, as previously discussed in relation to Recommendation 16.

Accordingly, steps have been taken to give effect to Recommendation 18.

²⁵ Government of Western Australia Department of Education, *Student Behaviour Procedures*, Department of Education, Perth, 2018, viewed 9 September 2018, p. 3
<<http://det.wa.edu.au/policies/redirect/?oid=au.edu.wa.det.cms.contenttypes.Policy-id-3781804>>.

²⁶ Government of Western Australia Department of Education, *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-injury*, Department of Education, Perth, 2017, viewed 9 September 2018, p. 2, <http://det.wa.edu.au/policies/detcms/cms-service/download/asset/?asset_id=19838833>.

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2.19 Recommendation 19

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

2.19.1 Background

The 2014 Investigation considered:

- the Department of Education's policy regarding enrolment and attendance by Aboriginal young people, set out in the *Student Attendance* policy; and
- the findings of the State Coroner's Inquests in the deaths of Aboriginal young people in the Kimberley in 2008 and Balgo in 2010, which recommended that:
 - 'there be a whole of government approach aimed at addressing truancy and its causes, particularly to Aboriginal students in the Kimberley'; and
 - 'students at educational risk as a result of truancy should be monitored and, when necessary, resources of a range of departments should be applied to addressing the issue.'

The basis for making Recommendation 19 was the Office's findings that:

- nine of the 10 Aboriginal young people in Group 1 attended school less than 60 per cent of the time;
- of the nine Aboriginal young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance; and
- of the 10 Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, four were suspended or excluded from school and no action was taken.

2.19.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that:

Consideration was given to clarifying documented planning requirements for Aboriginal students at-risk due to non-attendance within revised *Student Attendance* policy and guidance. The decision was to specify documented planning requirements for any student considered at risk. Aboriginal students, like all students, will be required to have a documented plan if they are at risk due to non-attendance, or if they fall into one or more of the categories identified

in the Department's *Guidelines for Implementing Documented Plans in Public Schools and Students at Educational Risk* policy. These are:

- students whose attendance is below 90 per cent or has been identified as a concern;
- students with significant behavioural needs who require an individualised behaviour program or who are subject to an exclusion order;
- students with disabilities who are eligible for or receiving supplementary resource provision; and
- students in the care of the Chief Executive Officer of the Department for Child Protection and Family Support.

In addition, all Aboriginal students participating in the *Follow the Dream: Partnerships for Success* program require an individual learning plan, as this forms part of the agreement for this targeted initiative.

The Department reviewed the annual survey data from 2012, 2013 and 2014 relating to Aboriginal students with personalised learning strategies. The action plan ceased at the end of 2014. The Department has implemented its *Directions for Aboriginal Education* in 2015. ACIL Allen Consulting completed a longitudinal evaluation of the implementation and outcomes of the national *Aboriginal and Torres Strait Islander Education Action Plan 2010-2014*. These reviews informed updates to support materials, which were published on the Aboriginal Education website.

Information and support material related to student attendance located on the Aboriginal Education website were provide; however these have since been removed as they have become outdated. More broadly across the Department, detailed information about attendance is accessible.

The Department has engaged with the Commonwealth in relation to specific strategies and initiatives to improve student attendance, including the *Remote School Attendance Strategy* (across 10 WA public Schools) and monitoring and reporting on *Closing the Gap* and COAG priorities and actions.

The Department of Education worked in partnership with the Commonwealth Department of the Prime Minister and Cabinet to host a forum for school staff, including principals, for schools engaged in the RSAS strategy.

Information and advice regarding attendance strategies was provided via a workshop for regional staff with responsibility for Aboriginal Education.

In a further report to the Office, the Department of Education advised the Office that:

The Students at Educational Risk policy is under review. The Department's Aboriginal Cultural Standards Framework informs the design and delivery of policies, programs and services for Aboriginal students and therefore the Department does not currently issue an annual Directions statement.

The Remote School Attendance Strategy (RSAS) continues to operate in 11 public school locations, with providers contracted to the Commonwealth, The

Department does not have an active role in RSAS by which implementation of an Ombudsman's recommendation can be pursued.

Accordingly, steps have been taken and are proposed to give effect to Recommendation 19.

However, as outlined in Chapter 8.4 of Volume 3, the Office obtained school attendance records from the Department of Education for the 50 children and young people in Group 1 that died by suicide after the 2014 Investigation period and identified that:

- 49 of the 50 young people in Group 1 attended a public school at some time during their lives;
- 38 of the 49 children and young people in Group 1 were enrolled at a public school during the last year of their life, and therefore required to be regularly attending school; and
- 23 (61 per cent) of those 38 children and young people in Group 1 enrolled at a public school during the last year of their life were not regularly attending school and were at 'severe educational risk' under the Department of Education's *Managing Student Attendance in Western Australian Public Schools* policy

The Office's analysis further identified that, of the 50 children and young people in Group 1:

- 27 were Aboriginal (54 per cent);
- 20 of the 27 Aboriginal children and young people in Group 1 (74 per cent) were enrolled in a public school during the last year of their life.

Of those 20 Aboriginal children and young people in Group 1 enrolled in a public school during the last year of their life:

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

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

Accordingly, the Office will continue to monitor, and report on, the steps taken to give effect to Recommendation 19.

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2.20 Recommendation 20

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

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

2.20.1 Background

The basis for making Recommendation 20 was the original investigation's findings that:

- 14 of 19 young people in Group 1 enrolled at school attended less than 60 per cent of the time, and limited action was taken to remedy this persistent non-attendance. However, a range of other actions, not required by the legislation or policy were undertaken;
- the names of two young people who died by suicide were on the list of students whose whereabouts were unknown in the year before their death. At the time they were on the Students whose Whereabouts were Unknown list, both of these young people had contact with other State government departments and authorities;
- ten of the 19 young people in Group 1 enrolled at school had been suspended or excluded from school, including five of the 19 young people who had been suspended from school for more than 10 days during a school year and three young people who were suspended for more than 20 days during a school year; and
- nine of the 10 Aboriginal young people in Group 1 attended school less than 60 per cent of the time and limited action was taken to remedy this persistent non-attendance.

2.20.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that:

The Student Attendance Reporting (SAR) database was enhanced with an Attendance Advisory Panel tab that provides cumulative live data. This has enabled schools to identify when a student's attendance falls below 60 per cent.

Consideration was given to a system of automated alerts in SAR to flag possible Students whose Whereabouts are Unknown (SWU) concerns. This option proved unfeasible due to limitations of the School Information System (SIS). When searching a specific child, the Student Information Repository (SIR) will display if the child has had any interaction with SWU database. ...

Consideration was given to the addition of a function in SAR to show when a student has previously been on the SWU list. Due to limitations in SAR this was not pursued. This capability has instead been developed for a new centralized database, SIR. Planning is currently underway to provide a range of reporting capabilities from SIR for regions to access. ...

Consideration was given to ways of supporting Education Regional Office and school staff to monitor students who are exhibiting difficulties and who are suspended from school on two or more occasions. The replacement of the suspension and exclusions database, with new capabilities to be incorporated in SAR, will facilitate this. In progress.

The Department established a dedicated position of Enrolment Information Coordinator to collaborate with the Student Tracking Coordinator and Transborder Coordinator to track students at risk due to attendance, transience or enrolment issues. ...

The Suspension and Exclusions database was decommissioned and replaced by enhancements to the Student Attendance Reporting (SAR) application. These enhancements have enabled school staff to monitor individual student suspensions at particular points (e.g. 10+ and 20+ days) and provide timely interventions. The database has also given regional staff opportunities to monitor schools' responses and intervene, as appropriate.

The School Performance Management System (SPMS) has provided each school with information about the percentage of students suspended in the calendar year. Schools above and well above the expected threshold are identified through a coloured flag report.

The mental health issues experienced by students, and schools' planned responses, have on a case by case basis been examined by Panels considering the recommendation of a student for exclusion. Training on consideration of disability, including mental illness and disorders, has been provided for regional staff who serve as or support executive officers on panels considering recommendations for exclusion.

Following each exclusion order, the Regional Executive Director has appointed a case manager to support the student and parents/carer, and to identify an appropriate alternative educational program for the student.

In a further report to the Office, the Department of Education advised the Office that:

The Attendance Advisory Panel tab in SAR was renamed Severe-Non-Attendance. The Attendance Advisory Panel information feature has been retained. The SIR database has been renamed Online Student Information (OSI).

The Department continues to track students at risk due to attendance, transience and enrolment issues.

The position of Transborder Coordinator no longer exists.

On the basis of the information provided by the Department of Education, it is apparent that consideration has been given to each of the four elements of Recommendation 20.

Accordingly, steps have been taken to give effect to Recommendation 20.

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2.21 Recommendation 21

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

2.21.1 Background

The basis for making Recommendation 21 was the 2014 Investigation's findings that led to the making of Recommendation 20, and additional information provided by the Department of Education during the 2014 Investigation that 'it has established and improved procedures by which student attendance can be tracked to identify students at risk.'

2.21.2 Department of Education report

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 a range of information in:

- reports prepared by the Department of Education; and
- meetings with the Department of Education.

The Department of Education relevantly informed the Office that:

The Department realigned its Statewide Services Division to improve support for schools and students. The Complex Behaviour and Mental Health team was amalgamated with attendance and behaviour policy custodians into a new Behaviour and Attendance branch. This new branch sits alongside School Psychology Services and a new School of Special Educational Needs: Behaviour and Engagement. Monitoring of emergent risks and proactive intervention by Statewide Services has been improved.

Procedures for case management of identified students at risk include referral to other agencies. Regional Education Office staff continue to monitor attendance, suspension and exclusion data to identify and respond to students at risk.

Regarding the use of the Department of Education's information to shape a collaborative inter-agency response for students at risk of suicide, as described in Recommendation 22, the Department reported to the Office that:

The Department, as part of the Schools Suicide Response and Prevention Project, has developed documentation and information sharing processes for students of significant/high suicide risk who are discharged from or involved with acute CAMHS services. This will enhance the exchange of information between CAMHS, the Department, CEOWA and AISWA.

The Department has developed, in collaboration with AISWA, CEOWA and CAMHS, practical guidelines for schools on managing suicidal behaviour and non-suicidal self-injury.

The Department has reviewed its school psychologist procedures and tools for assessment and case management of suicidal students. This included reviewing the defined communication process currently in use.

The Department has reviewed its social media suicide postvention guideline for schools.

The Department has developed and implemented quality assurance processes for the delivery of *OneLife Gatekeeper Suicide Prevention Program* (Gatekeeper program) to staff working in an education setting.

The Department has continued to host coordination of the Gatekeeper program on behalf of the Mental Health Commission.

The Department has conducted an audit into the number of school psychologists who are trained in the Gatekeeper program, and ensured that training is available for those who have not received training.

The Department has collaborated on the review and rewrite of the Gatekeeper program.

The Department has conducted an audit into the number of school psychologists who are trained in the use of Mental Status Examination (MSE). As part of this audit, the MSW, as used by the School Psychology Service, was reviewed.

In a further report to the Office, the Department of Education advised the Office that:

The Complex Behaviour and Mental Health team no longer exists, and the Behaviour and Attendance Branch was amalgamated with the Complex Behaviour and Wellbeing branch to form a new Student Wellbeing branch.

The *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury (Guidelines)* are currently being updated in consultation with relevant stakeholders. The Guidelines incorporate social media following a suspected suicide and linking schools with acute settings.

The Department School Psychology Service has developed Professional Practice Guidelines for *Mental Status Exam* and *Suicidal Behaviour and Non-Suicidal Self-Injury* to help guide Department School Psychologists' work in this area.

Mental Health Commission funding for the Gatekeeper Suicide Prevention Statewide Coordinator position ceased at the end of the 2018/2019 financial year. Gatekeeper training for school staff from the three school sectors continues through the Schools Response Program.

Department documents and processes, such as the Department coordinated interagency communication process following student suicide, are continually under ongoing review in line with contemporary research and practice.

Accordingly, steps have been taken to give effect to Recommendation 21.

2.22 Recommendation 22

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

2.22.1 Background

The 2014 Investigation identified that 19 of the 26 young people (73 per cent) were recorded as having experienced multiple factors associated with suicide and allegedly experiencing one or more forms of child maltreatment. These 19 young people were all in Group 1 and had contact with multiple State government departments and authorities during their lives.

The 2014 Investigation also cited an analysis of child deaths and serious injuries in the United Kingdom (**the UK Report**) as describing a profile of young people most at risk of death or serious injuries, similar to the young people in Group 1, who had experienced:

- A history of rejection and loss and usually severe maltreatment over many years;
- Parents or carers ... [who] misused substances and had mental health difficulties;
- By adolescence most were typically harming themselves ... and misusing substances;
- [Difficulties remaining] ... in school and placement.²⁷

The UK Report identified a theme of 'older adolescent children who were very difficult to help ... [with] a long history of high level involvement from children's social care and other specialist agencies'²⁸ for whom government and non-government agencies:

... appeared to have run out of helping strategies and were sometimes reluctant to assess these young people as mentally ill and/or with suicidal intent. Time was wasted arguing about which agency was responsible for which service and whether thresholds were met, thereby delaying the provision of services that the young people needed. There was a lack of coordination of services for these young people 'in transition' and failures to respond in a sustained way to their extreme distress which occurred in parallel to their very risky behaviour.²⁹

The Office noted that coordination of a range of suicide prevention actions relevant to these young people could be achieved through a joint case management approach, similar to the

²⁷ 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*, Department for Children, Schools and Families (UK), London, 2008, p. 12.

²⁸ 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*, Department for Children, Schools and Families (UK), London, 2008, p. 12.

²⁹ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth and J Black, *Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, Department for Children, Schools and Families (UK), London, 2008, p. 12.

model used in the Young People with Exceptionally Complex Needs program already in operation in Western Australia, and suggested that such a joint case management approach could involve:

- a comprehensive assessment to identify the young person's needs;
- a plan for addressing each of the young person's risk factors for suicide;
- as part of this plan, recognising that young people who have experienced multiple risk factors will be hard to engage and therefore require persistent outreach;
- a case manager;
- regular communication between all parties to the case management approach to monitor the effectiveness of their interventions; and
- review and updating of the plan to ensure services remain responsive to changing needs.

2.22.2 Mental Health Commission report

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 a range of information in:

- reports prepared by the Mental Health Commission; and
- meetings with the Mental Health Commission.

The Mental Health Commission relevantly informed the Office that:

In October 2014, senior officers from a range of government departments established an Interagency Executive Committee to action this recommendation.

The Committee requested further work to be completed by the MHC to estimate the number of children and young people who have a combination of the risk factors/indicators as identified by the Ombudsman. Members suggested that potential sources of data be identified from each organization and a data lineage report be requested.

In April 2015, the MHC met with representatives from the Telethon Kids Institute (TKI) to discuss the existing data analysis project on children with specific risk factors for deliberate self-harm, which included suicidal intent in light of meeting the requirements of Recommendation 22. ...

In response to a request for additional information regarding the steps taken to give effect to Recommendation 22, the Mental Health Commission reported to the Office that:

Repeated interagency consideration has been given to developing a shared screening tool. This includes the MHC facilitating a meeting between Child and Adolescent Mental Health Service, Department of Communities, Department of Education and Telethon Kids Institute on Tuesday 16 August 2016 to investigate ways that State government Departments and Authorities can prevent or reduce suicide in young people. The last meeting of a range of senior officers from relevant government departments including the Department of Communities,

Department of Education, Child and Adolescent Mental Health Service, [and] the MHC ... was held 10 November 2017.

The MHC is a commissioning agency and, while not directly involved in the delivery of services, does engage at an interagency level. For example, the MHC has been involved in the recently announced Target 120 initiative being overseen by the Department of Communities from both a policy and technical analysis/evaluation perspective.

The Target 120 initiative is a holistic program designed to reduce juvenile reoffending in Western Australia and improve community safety. It is a collaborative, targeted and flexible early intervention program, providing young offenders and their families with coordinated and timely access to the services they need.

While not solely targeting suicide, these children and young people do have elevated risk factors and some would be on the suicidal continuum.

If successful, the interagency approach being taken for this initiative could be expanded to include more risk factors than crime as the primary 'flag' to enter the program. However, this would require significant financial investment and interagency coordination.

Accordingly, steps have been taken to give effect to Recommendation 22.

However, as outlined in Chapter 9 of Volume 3, the Office's further analysis of the outcomes arising from the Interagency Executive Committee formed by the Mental Health Commission in response to Recommendation 22 has identified that:

- the proposed collaborative inter-agency approach for children and young people with multiple risk factors for suicide, shared screening tool and joint case management approach has not yet been developed and implemented in Western Australia;
- the Young People with Exceptionally Complex Needs Program has not been extended in scope; and
- since the 2014 Investigation some other jurisdictions have introduced collaborative inter-agency early prevention programs for enhancing the wellbeing of children and people.

Accordingly, the Office will continue to monitor, and report on, the steps taken to give effect to Recommendation 22.

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Appendix 1: Executive Summary of the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*

To assist the reading of this report, without further reference being required to the 2014 Investigation, the Office has reproduced the Executive Summary below.

1 Executive Summary

1.1 About the investigation

1.1.1 Functions of the Ombudsman

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

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

1.1.2 The Ombudsman's Child Death Review function

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

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

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

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

1.2 Characteristics of the young people who died by suicide

1.2.1 Young people whose deaths were notified to the Ombudsman

- Suicide is defined as the intentional taking of one's own life.³⁰ This investigation considers young people who died by suicide who were aged between 13 and 17 years.
- The Office of the Ombudsman (the Office) analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner has completed an investigation and found that the cause of death was suicide) or was suspected of having died by suicide (for those deaths where the State Coroner has not yet completed an investigation). In this report, these young people are referred to as the **36 young people**.

1.2.2 Demographic characteristics of the 36 young people

- The 36 young people ranged in age from 14 to 17 years at time of death. Four young people were aged 14 years, 10 were aged 15 years, 11 were aged 16 years and 11 were aged 17 years at time of death.
- Among the 36 young people, 22 (61 per cent) were male and 14 (39 per cent) were female.
- Thirty-three (92 per cent) of the 36 young people were born in Australia. Three young people were born outside Australia.
- Aboriginal young people were significantly over-represented among the 36 young people. Thirteen (36 per cent) of the 36 young people were identified as Aboriginal and 23 (64 per cent) young people were identified as non-Aboriginal. For comparison, six per cent of children and young people aged 0 to 17 years in Western Australia are Aboriginal.³¹
- The majority of the 36 young people were residing in the metropolitan area of Perth at the time of their death. Using regions defined by the Australian Bureau of Statistics,³² 21 young people were residing in a major city, six young people were residing in an inner regional area, three young people were residing in an outer regional area and six young people were residing in a remote or very remote region. Taking into account the numbers of young people residing in each of these regions, the mortality rates for the 36 young people who died by suicide were as follows:

³⁰ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 12.

³¹ Commissioner for Children and Young People, *Groups of children and young people in Western Australia: Wellbeing monitoring framework*, viewed 26 September 2013, <<http://www.cryp.wa.gov.au/maps/map.php>>.

³² Australian Bureau of Statistics, *2011 Census of Population and Housing*, cat. no. 2049.0, ABS, Canberra, 2011.

- 2.4 per 10 000 young people resided in a major city;
 - 5.4 per 10 000 young people resided in an inner regional area;
 - 3.2 per 10 000 young people resided in an outer regional area; and
 - 10.6 per 10 000 young people resided in a remote or very remote region.
- Applying the Australian Bureau of Statistics' definition of homelessness,³³ eight (22 per cent) of the 36 young people experienced at least one form of homelessness at some time in their lives. For comparison, Australian Bureau of Statistics census data reports that in 2011 less than 0.6 per cent of children aged 12 to 18 years were homeless at the census date.³⁴

1.2.3 Factors associated with suicide for the 36 young people

- The research literature identifies a range of risk factors, warning signs and precipitating events associated with suicide by young people. These are referred to here as factors associated with suicide. While no single cause of suicide has been identified,³⁵ the factors associated with suicide have been shown to increase the risk of suicide, particularly when multiple factors are present and interact with each other.³⁶ It is important to note that these factors are considered to be correlative, not causal.
- Several factors associated with suicide have already been discussed above as demographic characteristics of the 36 young people, namely, being male and experiencing homelessness. This section discusses the remaining factors associated with suicide experienced by the 36 young people.
- Records indicate that mental health problems were prevalent among the 36 young people:
 - twelve (33 per cent) young people were recorded as having had a diagnosis of mental illness; and
 - fifteen (42 per cent) young people were recorded as having demonstrated self-harming behaviour.
- Records indicate that suicidal ideation and behaviour were also prevalent among the 36 young people:
 - twenty two (61 per cent) young people were recorded as having had thoughts about attempting or completing suicide;
 - twenty (56 per cent) young people were recorded as having communicated their intention to commit suicide to a friend, family member or health professional; and

³³ Australian Government, Department of Health and Ageing, *Homelessness and mental health linkages: review of national and international literature*, Department of Health and Ageing, Canberra, 2005, viewed 26 September 2013, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-homeless-toc~mental-homeless-1~mental-homeless-1-2>>.

³⁴ Australian Bureau of Statistics, *2011 Census of Population and Housing: Estimating homelessness*, cat. no. 2049.0, ABS, Canberra, 2011.

³⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's business*, Department of Health, Perth, 2009.

³⁶ Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 12.

- sixteen (44 per cent) young people were recorded as having previously attempted suicide, with six of these young people recorded as having attempted suicide on more than one occasion.
- Child maltreatment consists of any act of commission or omission by a parent or caregiver that results in harm, the potential for harm or the threat of harm to a child, even if the harm is unintentional.³⁷ The Office examined allegations of child maltreatment of the 36 young people and found:
 - sixteen (44 per cent) young people were said to have experienced family and domestic violence;
 - nine (25 per cent) young people were recorded as having allegedly experienced sexual abuse;
 - eight (22 per cent) young people were recorded as having allegedly experienced physical abuse; and
 - twelve (33 per cent) young people were recorded as having allegedly experienced one or more elements of neglect during their childhood.
- Records indicate that, among the 36 young people, the frequency of adverse family experiences was:
 - thirteen (33 per cent) young people were recorded as having a parent who had been diagnosed with a mental illness;
 - eight (22 per cent) young people were recorded as having a parent with alleged problematic alcohol or other drug use;
 - five (14 per cent) young people were recorded as having a parent who had been imprisoned; and
 - three (eight per cent) young people were recorded as having a family member who died by suicide and four (11 per cent) had a friend who died by suicide or knew a person who had died by suicide.

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

- To analyse the factors associated with suicide, the Office grouped them into the following categories:
 - **Mental health problems**, which included having a diagnosed mental illness and/or self-harming behaviour;
 - **Suicidal ideation and behaviour**, which included suicidal ideation, previous suicide attempts or communicated suicidal intent;
 - **Substance use**, which included alcohol or other drug use;

³⁷ Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 25 February 2014, <<http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.html>>.

- **Experiencing child maltreatment**, which included family and domestic violence, sexual abuse, physical abuse and neglect; and
- **Adverse family experiences**, which included having a parent with a mental illness, having a parent with alleged problematic alcohol or other drug use, having a parent who had been imprisoned and having a family member, friend or person known to the young person who died by suicide.
- Through the analysis of the factors associated with suicide experienced by the 36 young people, the Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced. The four groups of young people also demonstrated distinct patterns of contact with State government departments and authorities. In brief, the four groups of young people are:
 - **Group 1** - 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Most of the 20 young people in Group 1 were also recorded as having experienced mental health problems and/or suicidal ideation and behaviour.

Records indicate that, as a group, the 20 young people in Group 1 had extensive contact with State government departments and authorities, schools and registered training organisations. All of the young people in Group 1 were known to the Department for Child Protection and Family Support. All had contact with WA Health, with eight young people having contact with the Child and Adolescent Mental Health Service.³⁸ Eighteen of the young people had contact with a government school and seven had contact with a registered training organisation. The 20 young people in Group 1 had significant contact with the State government departments and authorities associated with the justice system. The majority also had contact with the Department of Housing.
 - **Group 2** - five young people who were recorded as having been diagnosed with one or more mental illnesses, as having a parent who had been diagnosed with a mental illness and/or demonstrated significant planning of their suicide. None of the five young people were recorded as having allegedly experienced child maltreatment.

Records indicate that four out of the five young people in Group 2 had contact with WA Health and Child and Adolescent Mental Health Service. Three of the five young people had contact with a government school and two had contact with a registered training organisation. Records indicate that none of the young people in Group 2 had contact with the Department for Child Protection and Family Support, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.
 - **Group 3** – six young people who were recorded as having experienced few factors associated with suicide. None of these six young people were recorded as having allegedly experienced any element of child maltreatment, a mental health problem or adverse family experiences. All six young people were recorded as being highly engaged in school and highly involved in sport.

³⁸ Child and Adolescent Mental Health Service is a service administered by the Department of Health. For the purposes of this investigation, contact with Child and Adolescent Mental Health Service has been considered separately from other services administered by the Department of Health to identify access to specialised mental health services.

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

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

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

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

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

- The research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 entitled *The spectrum of interventions for mental health problems and mental disorders (the Mrazek and Haggerty model)*.³⁹ This model continues to underpin current thinking about suicide prevention strategies. The Mrazek and Haggerty model divides interventions for mental health problems into three categories - Prevention, Treatment and Continuing Care – and further into eight domains within these categories. The *Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business (the State Strategy)* is informed by the Mrazek and Haggerty model.
- The Office analysed how the patterns in the factors associated with suicide experienced by the 36 young people aligned with the categories and domains of suicide prevention activities as set out in the State Strategy. The Office found that the patterns in the factors associated with suicide experienced by each of the four groups of young people may be aligned with different, albeit overlapping domains of suicide prevention activities. This

³⁹ P Mrazek & R Haggerty (eds), *Reducing risks for mental disorders: Frontiers for preventative intervention research*, National Academy Press, Washington, 1994.

means that different suicide prevention activities may be relevant to each of the four groups of young people.

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

- The State Strategy identifies that it is focused on the Prevention category of the Mrazek and Haggerty model, which comprises activities that ‘... can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.’⁴⁰ The Office’s analysis also indicates that suicide prevention activities in the Prevention category may be important and should continue.
- In addition, the Office found that the factors associated with suicide experienced by 25 (69 per cent) of the 36 young people may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

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

- Records indicate that all of the 36 young people had contact with State government departments and authorities at some point in their lives. Records indicate that 31 of the 36 young people (86 per cent) had contact with multiple State government departments and authorities. These 31 young people were across Groups 1 to 4.
- Chapters 7 to 9 of this report, contain detailed analysis of the contact by the 36 young people with three State government departments and authorities. These are the Department of Health’s Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. The findings and recommendations in these chapters largely concern activities that align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model. These recommendations could be considered as part of the development of the State Strategy past 2013.

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

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

- The research literature identifies mental illness as a factor associated with suicide. Twelve of the 36 young people were recorded as having been diagnosed with a mental illness. All 12 young people were referred to the Child and Adolescent Mental Health Service (CAMHS) at some point in their lives. This contact presents an important

⁴⁰ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody’s Business*, Department of Health, Perth, 2009, p. 30.

opportunity to identify and treat mental illness and, in doing so, assist in preventing and reducing suicide by young people.

- Eight of the 12 young people were also recorded as having allegedly experienced at least one form of child maltreatment. These young people have been included in Group 1. The remaining four young people who were recorded as having been diagnosed with a mental illness were also recorded as having experienced self-harming behaviour, suicidal ideation and previous suicide attempts. However, none of these four young people were recorded as having allegedly experienced child maltreatment or any adverse family experiences other than a parent with a mental illness. These young people have been included in Group 2.
- The Office examined referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for the 12 young people who were recorded as having been diagnosed with a mental illness. The Office found differences between the experiences of the young people in Group 1 and Group 2, particularly with respect to acceptance of referrals by CAMHS and risk assessments. These patterns are discussed below.

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

- Of the 20 young people in Group 1, eight young people were recorded as having been diagnosed with a mental illness. All eight young people had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives.
- During the last year of their lives, six of the eight young people were referred to CAMHS again. However, three young people were not accepted by CAMHS even though they met the priorities for acceptance set out in the *WA Country Health Service Child and Adolescent Mental Health Services Access Criteria Policy*. The remaining three young people either received services from CAMHS or were waitlisted. Of the five young people in Group 2, four were recorded as having been diagnosed with a mental illness. Records indicate that, these four young people were diagnosed with a mental illness during the last two years of their lives. All four of these young people were referred to CAMHS. All referrals were accepted by CAMHS and the young people referred received services from CAMHS or were waitlisted to receive CAMHS services.

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

- Risk assessments, including risk of harm to self (self-harm and suicide), are required by WA Health's *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards (the CRAM Policy)*.
- For the eight young people in Group 1 who had been recorded as having been diagnosed with a mental illness, risk assessments were not generally undertaken at the three points where they were required by the CRAM policy, as follows:

- two risk assessments were undertaken as part of four admissions to an inpatient mental health unit; and
- six risk assessments were undertaken on 14 presentations to an emergency department with self-harm, suicidal ideation and/or behaviour.
- For the four young people in Group 2 who had been recorded as having been diagnosed with a mental illness, risk assessments were generally undertaken in accordance with the CRAM policy, as follows:
 - three risk assessments were undertaken on four admissions to an inpatient mental health unit;
 - five risk assessments were undertaken for six presentations to an emergency department with self-harm, suicidal ideation and/or behaviour;
 - CAMHS undertook three risk assessments after accepting five referrals. These three risk assessments undertaken by CAMHS included a psychosocial and biological component. All three young people for whom a risk assessment had been conducted also had a risk management plan in place.

1.5.4 Aboriginal young people

- Three of the eight young people in Group 1 who had been recorded as having been diagnosed with a mental health illness were Aboriginal. For these three young Aboriginal people:
 - all had been referred to CAMHS and for two young people the referral had been accepted by CAMHS, at some point in their lives;
 - all had been referred to CAMHS on more than one occasion, with a total of 11 referrals for the three young people; and
 - during the last year of their lives, two Aboriginal young people were referred again to CAMHS. Neither of these young people received services from CAMHS as a result of these referrals.
- The research literature has shown the effectiveness of culturally appropriate mental health services successfully engaging Aboriginal young people.⁴¹ This was also recognised in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, which recommended that government:

Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Services to assist Aboriginal people to access culturally secure Mental Health Services.⁴²

⁴¹ Australian Institute of Health and Welfare, *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people*, Resource sheet No 19, Australian Institute of Health and Welfare, Canberra, 2013, viewed 24 February 2014, <<http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs19.pdf>>.

⁴² B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Western Australian Department of Health & Mental Health Commission, Perth, 2012, p. 14.

- The findings of this investigation support this recommendation.

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

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

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

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

- Different forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse and neglect, often co-occur.⁴³ The effect of experiencing multiple forms of child maltreatment is referred to in the research literature as cumulative harm. Of the 20 young people in Group 1, 17 (85 per cent) were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm.
- The research literature also identifies that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments so as to recognise cumulative harm.⁴⁴
- Legislation and policies in some other states and territories explicitly identify that child protection authorities need to undertake holistic assessments so as to recognise cumulative harm. However, there are no explicit legislative requirements in Western Australia for undertaking holistic assessments so as to recognise cumulative harm.
- Some DCPFS policies for responding to child maltreatment address the need to undertake holistic assessments so as to recognise cumulative harm. DCPFS's *Policy on Neglect* explicitly identifies cumulative harm in its operational description of neglect⁴⁵ and

⁴³ Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 26 September 2013, <<http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html>>.

⁴⁴ L Bromfield & D Higgins, 'Chronic and isolated maltreatment in a child protection sample', *Family Matters*, no. 70, 2005, pp. 38 – 45.

⁴⁵ Government of Western Australia, Department for Child Protection and Family Support, *Policy on neglect*, DCPFS, Perth, 2012, viewed 26 September 2013, <<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Neglect-PolicyOnNeglect.pdf>>.

two further elements of DCPFS's policy framework contain indirect references to cumulative harm. However, the explicit or indirect recognition of cumulative harm has not been extended to other relevant elements of the DCPFS's policy framework.

- DCPFS procedures for responding to information that raises concerns about a child's wellbeing make one direct reference to recognising and responding to cumulative harm. This is contained in DCPFS's Casework Practice Manual, which explicitly identifies that a Safety and Wellbeing Assessment should involve 'some or all' of a number of tasks, including 'assess(ing) for the presence or risk of cumulative harm.'⁴⁶

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

- All of the 17 young people in Group 1 who were likely to have suffered cumulative harm were known to DCPFS, many through multiple interactions. The Office examined whether, for these 17 young people, DCPFS considered the potential for cumulative harm to have occurred by undertaking holistic assessments.
- The three key stages of DCPFS's procedures are: duty interactions; initial inquiries; and Safety and Wellbeing Assessments. The Office examined the assessments undertaken by DCPFS staff at each of these three stages and found:
 - for the 17 young people who were recorded as having allegedly experienced more than one form of maltreatment, DCPFS received information that raised concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an assessment of this information;
 - it was not possible to examine whether DCPFS assessed the potential for cumulative harm during the duty interaction process as information which would allow such an assessment to take place is not recorded by DCPFS;
 - For 12 young people in Group 1 there were 27 instances of intake and initial inquiries. During these initial inquiries there is evidence that DCPFS assessed the potential for cumulative harm, or progressed to a Safety and Wellbeing Assessment to enable this to be done, in 17 instances. DCPFS did not progress to a Safety and Wellbeing Assessment in two instances. In these two instances, DCPFS did not assess for the potential for cumulative harm; and
 - as part of 25 Safety and Wellbeing Assessments, there is evidence that DCPFS assessed the potential for cumulative harm in two Safety and Wellbeing Assessments.

1.6.4 Aboriginal young people

- Of the young people in Group 1, Aboriginal young people had higher levels of contact with DCPFS than non-Aboriginal young people, as follows:

⁴⁶ Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, DCPFS, Perth, 2013, viewed 26 September, <<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/01SafetyandWellbeingAssessment.aspx>>.

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

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

- The research literature identifies that educational institutions have an important role to play in reducing the incidence of suicide by young people as education professionals are in a unique position to identify and prevent the suicide of young people.⁴⁷ The research literature further identifies that educational institutions are particularly important for children and young people from certain groups, including young people who have experienced child maltreatment, and Aboriginal young people.
- All of the 20 young people in Group 1 were recorded as having allegedly experienced child maltreatment. Nineteen (95 per cent) of the 20 young people were enrolled in an educational program at the time of their death. Of these 19 young people, 17 young people were enrolled in government schools and two were enrolled in non-government schools at the time of their death.

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

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

⁴⁷ S. Crawford & N Caltabiano, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education*, vol. 34, no 23, 2009, p. 28.

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

1.7.2 Aboriginal young people

- Ten of the 20 young people in Group 1 were Aboriginal. Nine of the ten Aboriginal young people were enrolled with government schools at the time of their death.
- Nine of the ten Aboriginal young people attended school less than 60 per cent of the time in their last year of life. Attendance records for one young person were not available. The attendance patterns of the nine Aboriginal young people where records were available were as follows:
 - three effectively did not attend school in the last year of their life; and
 - six attended school less than 60 per cent of the time in the last year of their life.
- Of the nine Aboriginal young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance, pursuant to the *School Education Act 1999* and the *Student Attendance* policy. However, a range of other actions, not required by the legislation or policy were undertaken by schools.
- Of the ten Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, two were suspended from school for more than 10 days in a school year or excluded from school and limited action was taken under the *Behaviour Management in Schools* policy.

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

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

- In Western Australia, the primary piece of legislation regarding the safety and wellbeing of children is the *Children and Community Services Act 2004 (the CCS Act)*. As identified in a review of the CCS Act, sections 23 and 24A of the CCS Act 'enable agencies to share information, without consent where necessary, in the interests of the wellbeing of a child or class or group of children.'⁴⁸

⁴⁸ Government of Western Australia, Department for Child Protection, *Report of the Legislative Review of the Children and Community Services Act 2004*, DCPFS, Perth, 2012, p. 11.

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

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

- Nineteen of the 36 young people (53 per cent) were recorded as having experienced multiple factors associated with suicide and were recorded as having allegedly experienced one or more forms of child maltreatment. Most of these young people were also recorded as having experienced mental health problems and suicidal ideation and behaviour. These 19 young people were all in Group 1. The young people in this group had contact with multiple State government departments and authorities over their lifetime.
- The research literature identifies that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help',⁴⁹ and agencies face challenges in providing services to these young people.⁵⁰ The profile of 'hard to help' young people described in the research literature was similar to those young people in Group 1.
- Preventing or reducing suicide among young people, such as those in Group 1, who experience multiple risk factors is likely to involve a range of actions by a range of State government departments and authorities, which will need to be coordinated so that each action reinforces the others. One accepted way that such coordination can be achieved is through a case management approach. The young people in Group 1 had significant levels of contact with the Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. These departments could be important parties to a case management approach.

⁴⁹ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

⁵⁰ M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

Appendix 2: Recommendations arising from the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*

To assist the reading of this report, without further reference being required to the 2014 Investigation, the Office has reproduced the recommendations from the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people 2014*.

- **Recommendation 1:** As part of the development of the State Strategy past 2013, the Mental Health Commission considers developing differentiated strategies relevant to each of the four groups of young people, taking into account the findings of the investigation regarding the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities.
- **Recommendation 2:** The Mental Health Commission, in collaboration with relevant stakeholders, considers whether it may be appropriate to undertake, or facilitate the undertaking of, mental health literacy and suicide prevention activities for those young people who demonstrate few factors associated with suicide, as identified by the investigation.
- **Recommendation 3:** As part of the development of the State Strategy past 2013, the Mental Health Commission gives consideration to whether the scope of the State Strategy should be expanded to encompass the Treatment and Continuing Care categories of suicide prevention, by incorporating the investigation's recommendations about ways that State government departments can prevent or reduce suicide by young people.
- **Recommendation 4:** The Department of Health considers the findings of this investigation in determining their state-wide provision of mental health services for young people.
- **Recommendation 5:** The Department of Health ensures that Child and Adolescent Mental Health Service applies the priorities for acceptance of referrals set out in its policies.
- **Recommendation 6:** The Department of Health, where services are available, assists with the coordination of services from other government and non-government mental health services for young people who have been placed on a waitlist for services from the Child and Adolescent Mental Health Service.
- **Recommendation 7:** Where a young person is referred to the Child and Adolescent Mental Health Service but not accepted by the Child and Adolescent Mental Health Service, the Department of Health notifies the referrer that the young person has not been accepted.

- **Recommendation 8:** The Department of Health ensures that risk assessments undertaken by the Child and Adolescent Mental Health Service are conducted in accordance with the *Clinical Risk Assessment and Management* policy and the findings of the Chief Psychiatrist, including for young people who present with a history of child maltreatment.
- **Recommendation 9:** The Department for Child Protection and Family Support considers whether an amendment to the *Children and Community Services Act 2004* should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.
- **Recommendation 10:** The Department for Child Protection and Family Support considers the revision of its relevant policies and procedures to recognise, consider and appropriately respond to cumulative harm that is caused by child maltreatment.
- **Recommendation 11:** The Department for Child Protection and Family Support enables and strengthens staff compliance with the policies and procedures that are applicable to the duty interaction process.
- **Recommendation 12:** The Department for Child Protection and Family Support enables and strengthens staff compliance with any revised policies and procedures which require them to assess the potential for cumulative harm to have occurred as a result of child maltreatment.
- **Recommendation 13:** In considering revisions to its policies and procedures to recognise cumulative harm, the Department for Child Protection and Family Support considers incorporating requirements to consult with Aboriginal Practice Leaders when the potential for cumulative harm is being assessed for Aboriginal young people.
- **Recommendation 14:** The Department for Child Protection and Family Support uses information developed about young people who are likely to have experienced cumulative harm as a result of child maltreatment to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.
- **Recommendation 15:** The Department of Education ensures that schools comply with the requirements for addressing student non-attendance, as set out in the *School Education Act 1999* and the *Student Attendance* policy.
- **Recommendation 16:** The Department of Education considers expanding its *Student Attendance* policy to:
 - recognise that persistent non-attendance by a student may be due to cumulative harm resulting from child maltreatment;
 - recognise that these students may be at heightened risk of suicide;
 - set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
 - provide that, where this association is identified, it will be appropriately taken into account.

- **Recommendation 17:** The Department of Education ensures that schools comply with the requirements for managing student behaviour, as set out in its *Behaviour Management in Schools* policy.
- **Recommendation 18:** The Department of Education considers its expansion of its *Behaviour Management in Schools* policy to:
 - recognise that ongoing behavioural difficulties by a student resulting in multiple suspensions and exclusions may be due to cumulative harm resulting from child maltreatment;
 - recognise that these students may be at heightened risk of suicide;
 - set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
 - provide that, where this association is identified, it will be appropriately taken into account.
- **Recommendation 19:** The Department of Education ensures that schools comply with the additional requirements for addressing non-attendance by Aboriginal students, as set out in the *Student Attendance* policy.
- **Recommendation 20:** The Department of Education identifies young people who are exhibiting difficulties by establishing internal procedures to track when:
 - a young person's attendance has fallen below 60 per cent;
 - a young person's name has been placed on the Students whose Whereabouts are Unknown list;
 - a young person has been suspended from attendance at school on two or more occasions; and
 - a young person has been excluded from school.
- **Recommendation 21:** The Department of Education uses the information obtained through tracking attendance, suspensions and exclusions to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.
- **Recommendation 22:** The Mental Health Commission, working together with the Department of Health, the Department for Child Protection and Family Support and the Department of Education, considers the development of a collaborative inter-agency approach, including consideration of a shared screening tool and a joint case management approach for young people with multiple risk factors for suicide.

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Major Investigations and Reports

Title	Date
<u><i>A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce deaths of children by drowning</i></u>	November 2018
<u><i>Investigation into ways to prevent or reduce deaths of children by drowning</i></u>	November 2017
<u><i>A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities</i></u>	November 2016
<u><i>Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities</i></u>	November 2015
<u><i>Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people</i></u>	April 2014
<u><i>Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths</i></u>	November 2012
<u><i>Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004</i></u>	November 2011
<u><i>The Management of Personal Information - good practice and opportunities for improvement</i></u>	March 2011
<u><i>2009-10 Survey of Complaint Handling Practices in the Western Australian State and Local Government Sectors</i></u>	June 2010

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 • Fax 08 9220 7500

Email mail@ombudsman.wa.gov.au • Website www.ombudsman.wa.gov.au