Quantum
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Evaluation of the Kath French Secure Care Centre

Final Report

19 February 2019

ACKNOWLEDGEMENT

Quantum Consulting Australia acknowledges the people of the many traditional countries and language groups of Western Australia. It acknowledges the wisdom of Elders past, present and future and pays respect to Aboriginal communities of today. The term Aboriginal is used throughout this report and is used to represent both Aboriginal peoples and Torres Strait Islanders.

Evaluation team would like to acknowledge the commitment of the Department of Communities ('Communities') to children and young people in its care, in particular the staff within Communities. In conducting this Evaluation, the team encountered many staff who were thoroughly dedicated to assisting some of the State's most vulnerable young people

Graphics utilised on the cover page of this report have been derived from the graphics appearing on the *Department of Communities 2017-18 Annual Report*

DISCLAIMER

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Findings within this Report can be influenced by a number of unforeseen events that may occur outside of our control. Therefore, no assurance can be given that the findings contained within the Report will remain as such in the future.

Contents

Figures

Tables

ACRONYMS

Acronym	Definition
ASSIST	The client database system used by the Department of Communities
ATSI	Aboriginal and Torres Strait Islander
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CCSA	Children and Community Services Act 2004
CCYP	Commission(er) for Children and Young People
CEBC	California Evidence Based Clearinghouse for Child Welfare
CEO	Chief Executive Officer
CYF Act	*Children, Youth and Families Act 2005* (VIC)
CSO	Compulsory Supervision Order
DCP	Department for Child Protection
DFaCS	Department of Family and Community Services
DHHS	Department of Health and Human Services
DHS	Department of Human Services
EBP	Evidence-based practice
FACS	Family and Children's Services
FTE	Full-time Equivalent
GIRFEC	Getting it Right for Every Child
GP	General Practitioner
GSC	Good Shepherd Centre
IAO	Interim Accommodation Order
ISS	Intensive Support Services
KFSCC	Kath French Secure Care Centre
MHC	Mental Health Commission
MOU	Memorandum of Understanding
NAT	Needs Assessment Tool
NGO	Non-government Organisation
NSW	New South Wales
OoHC	Out of Home Care
PWI-SC	Personal Wellbeing Index – School Children
SIP	Service Improvement Plan
SSEN:BE	School of Special Educational Needs: Behaviour and Engagement
SWS	Secure Welfare Services
TCI	Therapeutic Crisis Intervention
VIC	Victoria
WA	Western Australia
YPECN	Young People with Exceptionally Complex Needs

Executive Summary

The Department of Communities[1] ('Communities') commissioned Quantum Consulting Australia to conduct an evaluation of the Kath French Secure Care Centre (KFSCC) service model and facility.

Background

The KFSCC commenced operations in May 2011 and is Western Australia's (WA) first secure care facility staffed by a multidisciplinary team where children are provided with up to 21 days of intensive support (and one possible extension of up to a further 21 days). The KFSCC offers a planned, short-term intensive trauma informed intervention for children and young people aged 12-17 years of age. In exceptional cases children under 12 years of age who are at extreme risk and where existing services cannot manage the risk can be admitted to the KFSCC. The KFSCC is intended to provide some of WA's most vulnerable children in out of home care (OoHC) with their best opportunity to stabilise and begin to address the complex problems and behaviours that prevent them from maintaining longer term placements and, where appropriate, transitioning to more independent living.

The KFSCC was established under amendments to the *Children and Community Services Act 2004 (CCSA)*, which came into effect on 1 January 2011.

Purpose of the evaluation

The purpose of the Evaluation is to address some of the *Statutory Review of the Children and Community Services Act 2004* (Statutory Review) recommendations relating to KFSCC that were tabled in the Parliament of WA in November 2017, and to consider the broader service system impacting on children with extremely complex needs. The scope of the Evaluation also includes assessment of the effectiveness of KFSCC as a protective intervention for children and identifying recommendations relating to the delivery of services for young people with complex needs, the secure care model, and legislative policy into the future.

Aligned with the Statutory Review recommendations, the aims and objectives of the Evaluation (the Evaluation Questions) are to:

i. explore the comparability of secure care services in other jurisdictions, including international models
ii. examine the extent to which the KFSCC is operating as intended
iii. provide evidence on the role and effectiveness of secure care as a protective intervention for children
iv. consider the appropriateness of the admission criteria and service model in identifying and responding to children in care with extremely complex needs

[1] Note, the Department of Communities was formed 1 July 2017 with the amalgamation of the Department for Child Protection and Family Support, the Department of Housing (including Housing Authority), Disability Services Commission, the Communities component of the Department of Local Government and Communities, the Regional Services Reform Unit and the regional coordination and engagement component of the former Department of Aboriginal Affairs. In this document we use the term 'Communities' to refer to the Department responsible for child protection matters.

v. identify the availability of alternative options to manage the behaviours of children under 12 years of age who have been held under a secure care arrangement
vi. examine the current barriers to transitioning children safely from the KFSCC
vii. identify intended and unintended outcomes for children admitted to the KFSCC, their families and carers
viii. determine if the building is fit for purpose to manage operational performance requirements
ix. examine the appropriateness of oversight arrangements, including the assessor model
x. identify service gaps and the allocation of resources across government to meet the needs of, and improve outcomes for, children with complex needs.

Evaluation methodology

The method of evaluation is summarised below. The key areas that the Evaluation focussed on included:

- the service model and whether it is appropriate to meet the intention of the KFSCC
- actual operations at the KFSCC
- outcomes and effectiveness of the KFSCC
- alternative options for young people and comparison to approaches in other jurisdictions
- the allocation of agency resources towards the intervention model.

The data and information used to inform the Evaluation and address the evaluation questions included a comprehensive document and literature review, database reviews and extensive stakeholder interviews and consultation.

Key findings

Following is an overview of the Key Findings for each Evaluation Question.

How are secure care services in other jurisdictions implemented?

There is very limited consistency in secure care models between different jurisdictions both within Australia and internationally. There is, therefore, a limit to the information that is comparable on a like-for-like whole of program/initiative basis. There are significant challenges in comparing models, not only due to their variations in design but also a lack of evidence to suggest that one method/model is more effective than another. The outcomes for individuals transitioning out of secure care are not well researched. Furthermore, the absence of Australian national standards with regard to secure care also makes it difficult to establish a basis for comparison across the different jurisdictions. Western Australia and Victoria share many similarities in design largely because Western Australia's secure care was modelled on the Victorian example.

To what extent is secure care operating as intended?

The Evaluation notes that secure care is largely operating as intended. However, in the seven years since secure care was established and the original intent described, the landscape of children in care and their needs is, according to those working in the sector, becoming increasingly challenging and more complex. This is most reflected in the younger age of children requiring secure care including those under 12 years of age, the prevalence of mental health needs of many children, the need for many children to be in secure care for as long as possible, and the lack of services and facilities for

children in care and exiting secure care with extremely complex needs. The number of Aboriginal children in secure care has also risen considerably over this time and this reflects the higher rates of Aboriginal and Torres Strait children in OoHC

The Evaluation noted that while the original intent of the Act may have envisioned for children to remain in secure care for the shortest period necessary to stabilise the child, there appears to have been a shift by the District to a view of 21 days as a "standard" expectation. This is likely to reflect a combination of:

- the limited accommodation options available that provide high level care/intensive supervision pertinent to a child exiting secure care
- the time involved in identifying a suitable placement option post secure care
- a discretionary overlay by KFSCC Management that the interests of the child are best served by working with the child over the maximum duration of 21 days (rather than a shorter duration)
- limited flexibility in the CCSA to facilitate modified programs and transition to the community.

When considering the intent of the Act, there is limited compelling evidence that the current maximum timeframes in which a child may be placed in secure care should be extended. Conversely, a number of factors support a view that the current operating model/approach may be resulting in children remaining in secure care longer than the intent of the legislation. These factors include:

- A number of the admissions into KFSCC comprise children experiencing substance use (alcohol and other drugs) and which can generally be stabilised within a 7 to 10 day timeframe. It is, however, acknowledged that other underlying risk factors are also present.
- Examples exist of operating models similar to that of the KFSCC where the duration of admission into secure care is less than the current duration occurring in WA – e.g. Victoria, where release of a child from secure care is generally occurring within a shorter time period (9 to 12 days[2]) than the current 18 day average for KFSCC, although as noted within this report, there are other factors that impact on length of stay in the Victorian secure care model.

Consultations with District staff highlighted a perception that the purpose of secure care had shifted from its initial intent of 'contain and assess' because of the lack of assessments taking place in KFSCC. The current limited assessment process at KFSCC was perceived as a gap by many District staff consulted. It was suggested that secure care provided an opportunity often not available to the Districts for accessing assessment services for young people some of which could be conducted by KFSCC staff, as well as bringing in other services as required.

Is the admission criteria and service model appropriate for responding to young people in care with extremely complex needs?

The Evaluation notes that the admission criteria are appropriate for identifying children with extremely complex needs, at an immediate and severe level of risk and whose situation requires intervention through the provision of removal and security. The consensus among external

[2] If the incidents of "overnight" stays is removed from the Victorian statistics, then the average length of stay would increase slightly from 9 days to approximately 11 or 12 days per stay.

stakeholders and District staff consulted was that the safety provided by the secure facility was effective for addressing many children's immediate needs, including an opportunity to assess and commence treatment of medical problems, and review their educational engagement. The reduction in the level of risk occurred primarily because it removed them from many of the sources of their risk and gave them some time to de-escalate. For children requiring this level of containment, secure care can be seen as acting as a 'circuit breaker'. However, as many of those consulted also acknowledge, some children's extremely complex needs are such that they quickly resurface after exiting secure care resulting in a strong likelihood of their return to dangerous risk levels sometimes requiring further admissions to secure care.

Consideration of the appropriateness of the admission criteria and secure care service model in responding to children with extremely complex needs inevitably includes the length of time a child is in secure care. As identified in the preceding section, the average stay of 18 days for children at KFSCC, is, in the view of most stakeholders, necessary and, for some, an effective, albeit often short lived, circuit breaker. There is, however, a "tension" that may occur between the intent of the CCSA in regard to the maximum duration of stay within secure care with that of a general view that the full 21 days (if not longer) provides greater opportunity to work with the child in relation to assisting the individual with their underlying risk behaviour issues. Currently, the process associated with reaching a decision on whether the legislative criteria/threshold for admission has been met, incorporates an element of interpretation. In such instances, a conservative approach should be applied that acknowledges that no child should be deprived of their liberty unless as a measure of last resort and then for the shortest appropriate period of time.

What are the current barriers to transitioning children safely from secure care?

An effective transition from secure care is critical to sustaining any positive outcomes achieved during the secure care period, to the continuity of care and enhanced care a child receives, and to reducing the risk of them re-entering secure care. The Evaluation identified many barriers to children transitioning from secure care. These include:

- limited suitable placements available
- no step down service or specific placement options from secure care
- uncertainty about the next placement, disrupting a child's stabilisation both before and on exit
- impact of the contrast between the secure care environment and the next placement
- not being able to place Aboriginal children consistent with the Aboriginal and Torres Strait Islander Child Placement Principle, with many being kept off country which often added to trauma levels and a longer-term placement breakdown
- limited support services after secure care especially in regional areas
- lack of inter-agency collaboration for planning a child's reengagement and ongoing support.

Many of the barriers appear to lie with the broader OoHC system and the multiple pressures it faces. These barriers include the lack of a dedicated child and adolescent mental health service for children in care, and an insufficient number of high needs placements – particularly in remote regions. These have challenged the sector's ability to consistently deliver stable and healing care and living arrangements, especially for vulnerable children.

Communities is working to develop and implement a number of reforms to respond to the pressures on the OoHC system. The Statutory Review noted that the reformed service system should increase and appropriately resource community-based placement options and reduce the number of secure

care readmissions. However, at the time this evaluation was conducted, many of the challenges of the OoHC system remain and were repeatedly identified during the consultations as barriers impacting on the need for the effective transitioning of children from secure care.

The need for a multi-agency response for children exiting secure care and with complex needs is a consistent theme. The interaction of relevant agencies would ideally occur within a set of agreed processes and commitments that facilitate multi-disciplinary teams and ensure access to resources and services required for an effective response. While various attempts have been undertaken by Communities to collaborate with other agencies, consultations overwhelmingly suggest that more work needs to be done to develop a culture of shared decision making and responsibility between relevant government agencies and external organisations with regard to children in and transitioning out of secure care.

What are the intended and/or unintended outcomes for children in care who have been admitted to the KFSCC?

Analysis of Communities records and stakeholder consultations highlight a number of intended outcomes for children in secure care. These include ensuring the child's immediate safety, a de-escalation of stress and anger, removal of the source of a range of risk behaviours and establishing routine. Secure care also aims to meet the basic needs of children as well as working to address some of their dynamic risk factors, such as substance abuse, emotional dysregulation, impulsivity, violence and self-harming, amenable to deliberate and immediate intervention. Other intended outcomes include the treatment of health issues, provision of nutritious meals, and raising awareness about safe and protective behaviours.

The Evaluation noted some unintended outcomes relating to being *off country* and away from community for Aboriginal children, the impact of how some critical incidents are responded to (e.g. resulting in transfer to detention on some occasions), and the impact of leaving secure care (e.g. in some instances, with little time for planning transition. There can also be further challenges due to complex socio-cultural factors, specific culture-bound syndromes and the limited availability of culturally appropriate mental-health services.

The Evaluation notes that existing Communities data collection systems do not readily enable the identification of medium or longer-term outcomes with regard to the impact of a secure care arrangement. The Evaluation conducted a review of case files and discharge summaries for a purposive selection of children who had been in secure care. The focus of the review was to confirm admissions followed legislative criteria and policy and procedure. It is not possible to extrapolate findings from the case file review to the wider population. In this regard, the Evaluation proposes that an enhanced monitoring and evaluation framework be established to assist in the collection of data that will provide a means by which Communities can identify certain outcomes and have greater insights into the trajectory of the secure care cohort. The Evaluation acknowledges that this will be difficult with regard to older children who are close to leaving the OoHC system.

Is the secure care model effective as a protective intervention for children?

To determine whether secure care operates as an effective protective intervention for children in WA requires consideration not only of the immediate and short-term impact of secure care (in regard to keeping children safe from harm to themselves and others) but also with respect to the medium and long-term impact of being detained for a period of time in an unfamiliar environment.

From the interviews with past and current children placed at the KFSCC, and from the feedback forms completed by children and file reviews, it is clear that admission provides for a cessation of risk behaviours for most children – with only a few continuing to self-harm or assault others once admitted. In this regard, the model appears to provide an effective protective intervention for children in secure care. However, for a comparatively small number of children the period in secure care does not appear to disrupt their trajectory and they continue to engage in behaviours that place themselves and others at risk after release from secure care. This would suggest that, while secure care might provide a short-term risk management option for these children, additional intervention is required to mitigate their medium to long-term risks.

Are there alternative options for managing the behaviour of children who are under 12 years of age?

A review of a sample of twelve (approximately 25%) of the relevant case files identified a cohort of children under 12 years of age admitted to KFSCC with mental health needs and those who require, but are without, a mental health professional's ongoing involvement and treatment. This finding is consistent with the findings of the Department's review which identified a high prevalence of children with significant mental health conditions but less than half being referred to Child and Adolescent Mental Health Services (CAMHS) and many not being engaged in any current mental health treatment.

The Evaluation notes that there is an absence of specialist service models available to meet the complex health needs of very young children in Communities care and for the younger children admitted to secure care this represents a significant concern. While there are some public and private mental health services for children in WA, these are largely not readily accessed or accessible by children in care with complex mental health needs and challenging behaviours, many of whom require a purpose designed service rather than a traditional out-patient clinic model. The development of specialist units for disengaged youth and for young people with eating disorders are examples of current services specifically designed to meet the needs of a group of children and adolescents not well catered for in the general CAMHS and private mental health system.

Access to private mental health services under the Australian Government's *Better Access to Mental Health Care Initiative* has improved, however, these are focused on mild to moderate mental health conditions managed through primary and secondary health providers. While the initiative has improved the rate of treatment for adults with mood disorders and, to a lesser extent, children and adolescents, there appears to be little impact on severely disturbed younger people.[3]

The Evaluation identified the need for a well-resourced, high quality specialist therapeutic support service in WA focussed specifically on meeting the mental health needs of children and adolescents in OoHC (for example the 'CAMHS Children in Care' operating in the Surrey CAMHS in the United Kingdom). It is noted that the Mental Health Commission (MHC) have publicly stated an intent to develop a specialised unit for children in care with mental health diagnoses as a matter of urgency. It would be important that any dedicated service for children in care be inclusive of younger children.

[3] Pirkis, J. & Ftanou, M. (2011). Evaluation of the better access to psychiatrists, psychologists and general practitioners through the Medicare benefits schedule initiative: summative evaluation.

Is the physical environment fit for purpose to manage operational performance requirements?

The KFSCC facility is generally configured to meet the requirements of a secure facility with appropriate physical barriers and electronic monitoring. However, specific design shortcomings include:

- A lack of a separate entry and "Admissions Room" (accessed via a purpose built/specific entrance door to the facility).
- Video conference equipment is housed within a meeting room within the management and administration section. Accordingly, use of video conferencing requires children to access the relevant room via the working/office area of management and administration personnel. This represents a risk.
- The layout of the KFSCC building has limited common passage access and results in access to bedrooms, the kitchen and education rooms via the lounge areas – this creates challenges during critical incidents including use of restraints and transfer to the safe room and limits capacity for low stimulation space during the winter months.
- There is limited provision of floor space/room configuration to enable older children to participate in independent, age appropriate, life skill activities.
- General internal finishes and furnishings are not reflective of contemporary guidelines in secure facilities[4] (e.g. comfortable welcoming environment with domestic furnishings, décor and artwork and a dedicated area/room (with sensory modulation fit out) as a means of reducing the potential for aggressive behaviour) etc.)

Is there sufficient oversight in place?

Communities oversight of the KFSCC, including the Assessor process, requires processes that provide for greater accountability and community confidence. Recommendations by this Evaluation to enhance current procedures and policy documents regarding the operations of secure care are intended to provide mechanisms for increased departmental oversight of secure care admissions, extensions, and the decision-making processes of KFSCC Management.

The Evaluation notes that there is currently limited publicly available information about the operations of the KFSCC. The Communities Annual Report, which is intended to provide public information on the KFSCC performance, provides data on one indicator being the average cost per day; and some general comments. There is no detail about occupancy rates, the number of admissions, length of stay, etc. Greater emphasis on public accountability would assist to build confidence in the operations of the KFSCC. There is also a need to ensure recognition is accorded to children's rights and experiences whilst in secure care, and greater emphasis should be placed on ensuring children's access to an independent advocate as a means by which their rights can be assured and their views incorporated in assessment processes, including those who have exited secure care.

The Statutory Review considered the operation and effectiveness of the oversight provisions in some detail. It noted the distinction between systems oversight of the secure care facility, and oversight of the processes and procedures governing individual secure care arrangements. Submissions to the Statutory Review emphasised the need for heightened independent oversight of the secure care

[4] E.g. Australasian Health Facility Guidelines, Part B - *Health Facility Briefing and Planning 0132* - Child and Adolescent Mental Health Unit.

facility. The Statutory Review concluded that the "locked nature of the facility requires a higher degree of independent oversight than the current section 125A model allows" and should be assigned to an entity "completely independent of the Department." The Evaluation supports this finding from the Statutory Review.[5]

Can resources be allocated more efficiently to address service gaps in the system?

Memoranda of understanding (MOUs), bi-lateral agreements and the Rapid Response Framework have all intended to improve multi-agency case work and respond effectively to children with extremely complex needs. Despite this, the Evaluation noted limited examples of highly effective multi-agency responses toward children in care and especially those with complex needs including those in secure care. Effective communication and collaboration between Communities and other agencies is a key enabler to responding to children with complex needs and improving children's outcomes post secure care. These gaps contribute to a lack of alternative options and services for children at extreme risk and with ongoing complex needs.

In this regard, the Evaluation supports recommendation 47 of The Statutory Review regarding the need to prioritise the provision of all necessary government services to children in care. This would have particular relevance to children transitioning out of secure care in order to reduce the potential for readmission.

There is an urgent demand for more high needs placements to ensure such services are available to children in care who require them both before and after secure care. There is also an urgent need to introduce proposed reforms to OoHC to fund these intensive placements, so they have capacity and expertise to accommodate this cohort of children.

Monitoring and evaluation framework

The proposed Monitoring and Evaluation Framework (M&E Framework) is designed to establish the structure by which to measure and monitor the activities of the KFSCC and assist Communities to track outcomes for young people admitted to secure care. It has been designed as a flexible framework intended to establish an evidence base and enhance the planning, implementing, and reporting of the secure care model. The M&E Framework defines the aims, key indicators, type of data to be collected, data sources and reporting methods.

From an overall perspective, the M&E Framework takes into consideration that secure care exists within a continuum of care for young people and that the KFSCC is a part of the broader OoHC system that seeks to serve the needs and wellbeing of young people in care.

In particular, the aims of the M&E Framework are to support:

- The provision of evidence of the impact of secure care during and post an admission.
- Understanding of the relationships between the secure care model and the broader OoHC system in which it operates.
- Improved planning and decision-making by identifying the most effective aspects of secure care and barriers to its intended aims.

[5] Refer Recommendation 23 from the Statutory Review

- Creation of a secure care evidence base which can continue to be developed as part of the ongoing management and refinement of secure care and the care provided to young people with extremely complex needs.
- A common direction across Communities about what is required to ensure secure care is operating as intended.
- Accountability of, and confidence in, the secure care model.

Monitoring and Evaluation - Indicators

Data collection for monitoring and evaluation comprises two levels:

i. Operational data (e.g. occupancy rates, pending referrals etc.) focusing on short to medium term KFSCC activity.
ii. Outcome data (e.g. stabilisation in problematic behaviour etc.) focusing on establishing an evidence-base regarding the impact of secure care, from admission through to exit from secure care and short term follow-up.

The first level of the M&E Framework is focused on how KFSCC operates at a system level by identifying key performance indicators that relate to daily operational activities of the KFSCC. It provides management of the KFSCC with a mechanism for collating current activity data that can be utilised to identify and address current operational issues. This data collection also provides Communities with enhanced oversight of the operations of the KFSCC. Operational data establishes a form of "clinical governance" and embeds a quality assurance approach that allows for evidence-based decision making and empirical evaluation of quality improvement initiatives and projects.

Outcomes of the KFSCC model are classified into immediate (at point of exit from the KFSCC) and medium-term outcomes for which the KFSCC can make some contribution. The M&E Framework has been developed with an acknowledgement that Communities has control over their inputs and activities, influence over the immediate-term outcomes and an interest in the longer-term outcomes. These longer-term outcomes (i.e. after a child has exited KFSCC) are subject to a variety of factors/variables external to the KFSCC model. The M&E Framework asks Communities to adopt a systems approach to monitoring and evaluation that seeks to engage other agencies in monitoring outcomes for children and young people over the longer-term and across the systems they are in contact with.

KFSCC Service Improvement Plan

Linked to a quality assurance and improvement framework is a process to reflect on findings or outputs of the M&E Framework for the KFSCC. The collection of baseline data will allow for the evidence based evaluation of initiatives and modifications and, where appropriate, the opportunity to compare with other similar services.

Such mechanisms should include 'self-evaluation' sessions where staff reflect on what they consider the secure care service does well, and what it could do better. When collated with other stakeholder views this information can be fed directly into a KFSCC *Service Improvement Plan* - with specified target dates for actioning and allocated responsibilities. The Service Improvement Plan would be reviewed annually.

Recommendations

Provided below are the Recommendations of the Evaluation.

The following table identifies (for each Recommendation) the section in the Evaluation Report relevant to the Recommendation, the key findings (identified in the Evaluation) that support or underpin the Recommendation. Also identified in the table is impact or change that is anticipated to occur as a result of implementing the Recommendation.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
To what extent is secure care operating as intended				
1	2.2.5	(If not already undertaken) That a comprehensive assessment of children admitted in to KFSCC be undertaken comprising: • Screening for particular conditions (e.g., intellectual disability, depression, anxiety) and a comprehensive bio (medical)-psycho (Mental State Examination and screening for mood disorders) and social (peer/staff interactions) assessment; and • Educational functioning/needs.	i. A secure care arrangement provides an opportunity for the provision of basic assessment services to establish a current understanding of the child's mental health and needs and the presence of other conditions that may not have been identified due to their circumstances. ii. For a number of children admitted to secure care, little is known about the predisposing or "dynamic" factors that have escalated the behaviours and related risks of children being admitted to secure care. iii. A common theme from District Director feedback is that upon exit from secure care, the likelihood/ability of CAMHS to engage with and provide clinical services to the young person is limited.	• Establishes a current status on children in secure care from which to identify appropriate supports post secure care and measure social, health and wellbeing outcomes both during and following secure care.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
			iv. Data indicates a high proportion of young people admitted to secure care have mental health concerns identified on their referral. v. The therapeutic pack currently compiled by the KFSCC is based on case files and information accessed about the child prior to their secure care admission and before they have met or spoken with the child. This results in secure care staff working with information that may not be very complete with regard to the child's immediate needs and issues.	
2	2.2.5 See also Sections 2.2.2.1, 2.3.2 & 2.6	i. That the current *Policy on Children Entering Secure Care* be further developed to provide greater clarity and guidance in interpreting the wording of the CCSA with regard to Section 88C "*there is an immediate and substantial risk of the child causing significant harm to the child or another person*" for referrals with accompanying standard (controlled) forms and practice notes. ii. That a policy be developed regarding when KFSCC is near or at capacity to provide transparency in regard to the determination of referral consideration.	i. Currently, the Act and Department Policy does not provide guidance on the readmission of children soon after discharge (i.e. readmission after one day is not viewed as an extension of prior admission) and is not clear on referrals for short period readmissions or the grounds for extensions to secure care arrangements. ii. A risk management issue exists in that the current process is reliant upon the interpretation of the Act by a handful of key KFSCC senior management and Communities executive personnel. iii. What should occur in instances where KFSCC is near to, or at capacity, particularly relevant for facilities with a limited number	• Provides greater clarity, instruction and transparency for all staff and stakeholders. • Will facilitate more information on specific risks and how admission to KFSCC will assist in addressing those factors. • Will remove any basis for suggestion or potential for bias or undue influence in the referral process by KFSCC Management. • Greater adherence to the intent of the CCSA.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
			of beds available. Such a policy will assist in providing clarity in addressing a scenario where the facility is at capacity and yet, new and additional children meet the threshold for admission to secure care.	
3	2.2.5 See also Section 3.5	Address the specific cultural needs of Aboriginal children entering secure care by: – Assessing the Aboriginal cultural competency of all KFSCC staff through the application of the Aboriginal Mental Health Cultural Competency Profile and provide appropriate responses. – Ensuring the Culture and Identity Plan is included in the KFSCC referral supported by consultation with a relevant Aboriginal Practice Leader to identify and inform the admission process around any particular culturally relevant issues that might impact the admission of the young person.	i. Consistent awareness across Communities of the need to appropriately respond to Aboriginal children and ensure their cultural safety.	• Enhance the competencies of staff to provide diversified strategies and responses to Aboriginal children in secure care, including their unique mental health needs.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
Is the admission criteria and service model appropriate for responding to young people in care with extremely complex needs				
4	2.3.4 See also Sections 2.1.3.2 & 2.2.2.2	Consideration be given to formalising a process of review (at ten working days) in a secure care arrangement in conjunction with an independent person/body to reassess the extent to which the child still meets the admission criteria.	i. Most stakeholders (KFSCC staff, Districts) are operating under the assumption that seeking a secure care arrangement for a 21 day period is 'standard' even if many children typically stabilise by week two. ii. Consensus among District staff consulted was that seeking the maximum period of time for a secure care arrangement is necessary to develop an exit plan and identify a placement option for a child with complex needs, which is inconsistent with the Act. iii. Admission into secure care is largely based on an internal decision making process. iv. Secure care model in Victoria provides an example where the duration of admission into secure care is less than the current duration occurring in WA.	• May provide means for more children to exit secure care earlier than the current average of 18 days. • Will provide greater adherence to the original intent of the Act being that secure care is for the "shortest [period] necessary". • Will align secure care procedures with those under the *Mental Health Act (2014)* with similar human rights protections.
5	2.3.4 See also Sections 2.2.2.1; 2.2.2.5 & 3.5	The completion of "youth mental health first aid" or similar training be a compulsory component of staff induction to KFSCC.	i. A sample of recent referrals (case file reviews), KFSCC staff surveys and consultations with District staff suggest children are admitted to KFSCC with varying mental health issues and conditions. ii. While acknowledging the value of having a trauma-informed approach, the training in the Sanctuary Model is not considered	• Will upskill KFSCC staff to a basic minimum level of competency to work with the population of children referred to secure care. • Provides for a validated approach to supporting

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
			sufficient preparation for managing the many mental health needs of the children admitted to KFSCC which, while predominately thought to be trauma related, cover a wide range of mental health conditions.	children's mental health needs.
6	2.3.4	Consider introducing a structured therapeutic planning document with a set of guidelines that specifies particular programs/modules (e.g. evidence based, culturally appropriate, etc.) to support the delivery of tailored/diversified brief interventions.	i. Currently the KFSCC complete an assessment of the child's apparent needs based upon the referral information and initial assessment of the child's presentation. ii. It is acknowledged that KFSCC implements a number of brief interventions such as sexual health, substance use, etc. however the efficacy/effectiveness of these is not tested.	• Provides more rigour and standardisation to delivery of interventions and a means to evaluate pre and post outcomes (e.g. awareness, alternative strategies, etc.); and identify areas requiring a more focused response.
7	2.3.4 See also Section 2.2.2.5	Consideration be given to developing daily activities, as the site permits, to better support the needs and circumstances of older children at KFSCC especially with regard to enhancing independent living skills, supporting positive resilience and coping strategies.	i. Feedback forms and interviews suggest older children/young people are not accessing age/life experience appropriate activities and opportunities in secure care. Comments include being bored, not having enough to do except watching TV and playing Xbox. ii. Currently the content of many 'learning activities' at KFSCC cater to younger children with an emphasis on play based learning. iii. Older children in secure care require meaningful activities and learning programs that foster life skills and a sense of purpose.	• Will serve to promote young people's sense of capability and resilience, and support the development of life skills and attitudes, that will assist them in reengaging into the community.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
What are the current barriers to transitioning children safely from secure care				
8	2.4.4 See also Sections 2.2.3.1 & 2.3.2.4	Additional high support placements be made available to facilitate a staged or "step-down" approach for some/selected young people exiting secure care.	i. Consultations and research reviewed confirm the critical importance of positive transitioning experiences for sustaining children's stabilisation after secure care. ii. Widespread agreement that the experience of leaving secure care can escalate children's stress triggers. Lack of placement certainty and adequate preparation for children's exit, and withdrawing from staff and routines were identified as contributing to this issue. iii. Lack of placement certainty for many children prevents planning for support services immediately following a secure care arrangement because service providers (Government or Non-Government Organisations (NGO)) require an address for the child before they will commit to a referral.	• Potential to reduce the duration that a child is detained in secure care. • Provides for additional time for a suitable and longer term placement option to be identified/arranged. • Reduces the stress and issues associated for those not knowing where they are going after secure care. • Provides a known location for the commencement of intervention programs and support services. • Provides for continued contact with some KFSCC staff (including Lead Clinical Psychologist) where considered appropriate.
9	2.4.4 See also Sections 2.3.2.4; 2.10 &	Establish an MOU between Communities and the Department of Education for access to the School of Special Educational Needs: Behaviour and Engagement (SSEN:BE) liaison and in-reach support.	i. Consensus identified among District and KFSCC staff that children in secure care have been disengaged from a formal education system for some time, and face many challenges re-engaging into any system.	• Will assist in providing required support for individual students with the most extreme, challenging and complex educational needs. • Will work to ensure that each

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
	Appendix A	The SSEN:BE liaison to continue for a short duration post exit from secure care (e.g. for eight weeks post exit) as part of a "step down" process.	ii. KFSCC and District staff recognise children in secure care need additional supports with their education including facilitating their re-engagement with education after secure care. iii. Of the 16 secure care admissions from January –April 2018, five children had an Education Plan recorded in their files following their secure care arrangement. Of these, three had no previous Education Plans recorded in their files and two had an Education Plan recorded in their files in 2017. Three children had an Education Plan recorded in 2015, one in 2014 and three in 2017.	child in the Chief Executive Officer's (CEO's) care, of compulsory school age, has a Documented Education Plan that is regularly reviewed as required by the MoUs • Supports the development of children and young people's positive attitudes to learning and reengaging into the community.
10	2.4.4 See also Appendix B	Develop a transition protocol that includes a schedule of transition activities (providing details of placement and opportunities to view premises by video or photos) for use by KFSCC staff. This protocol would include: • early provision of information about the transition process and next placement (if known) • ensuring the child's communication with a nominated staff member at the next placement (if known)	i. High risk period for young people as evidenced by patterns of increased critical incident and common observations (discharge summaries, KFSCC daily notes etc.) that exiting secure care heightens distress of the young person. ii. A documented transition protocol/procedure does not currently exist.	• Will formalise and enhance procedures for assisting/supporting young people transition from secure care. • Will allow for quality assurance and improvement.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
		• an emphasis on all KFSCC staff discussing the different types of placement children may encounter (and ways that children might approach these various placements) if they have concerns.		
What are the intended and/or unintended outcomes for children in care who have been admitted to the KFSCC				
11	2.5.4 See also Section 3.3	Communities to conduct yearly record audit of all secure care admissions based on a quality assurance and quality improvement framework.	i. Monitoring and evaluation processes are not embedded or utilised by KFSCC in a systematic way. ii. Minimal analysis of KFSCC staff daily rating scales in the Discharge Summary and no indication as to how the data collected is entered into the systems utilised by the KFSCC, no evidence of the outcomes arising from use of the Westerman Aboriginal psychometric checklist with Aboriginal children. iii. Data reviews identified that current data collection systems do not readily enable an assessment to be made as to whether the secure care model is effective as a protective intervention over the medium to longer term.	• Provides for baseline data and facilitates monitoring of particular outcomes including readmissions, placement stability, engagement with support services, education and juvenile justice. • Assists in the identification of trends and gaps and provides greater understanding of the secure care cohort over time. • Enables the measurement of the impact of any quality improvement projects.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
Is the secure care model effective as a protective intervention for children				
12	2.6.4 See also Sections 2.2.2.2; 2.4.2.2 & 2.5.2	A policy be developed that provides for an escalation of a case to be reviewed at the Executive Director level in Communities (and an option of referral to a coordinated multi-agency review) if a child has more than three secure care admissions in a 12-month period.	i. No apparent process in place for reviewing cases of multiple admissions occurring in a relatively short period of time. In instances such as this, consideration of secure care as an effective intervention should be reviewed. ii. Consultations confirmed the involvement of senior officials from external agencies is only occurring in the most extreme cases. iii. Consensus identified that there are many service gaps in cases of multiple secure care admissions and the need for a collaborative interagency response as critical to managing and reducing the risks. iv. Evidence of models such as Young People with Exceptionally Complex Needs (YPECN) being effective in bringing senior level agency representatives together and having potential to be effective.	• Facilitates input and consideration at the Executive level of a review of multiple admissions and would allow for high level coordination of services for children which have not substantially benefited from multiple admissions to secure care.
13	2.6.4 See also Section 2.2.2.2	Policy and supporting forms be developed to facilitate consistency and further clarifying particulars of content in applications for extensions.	i. Consultations identified a perceived ambiguity among District staff consulted for the Evaluation regarding the criteria/rationale (threshold) to be applied when considering an application for extension.	• Provides clear guidance to secure care management and Districts in regard to grounds for extensions and addresses a risk of secure care being utilised as a placement option in the absence of any

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
			ii. A review of 52 successful applications for extension indicated that 32 made direct reference to a continuing high level of risk, 26 indicated the lack of available appropriate accommodation, and 31 listed a lack of engagement in the program or a failure to progress towards goals as the basis for extensions. iii. Analysis of applications for extensions indicates differing interpretations as to what constitutes "exceptional reasons" as grounds for extension.	alternative placement arrangements.
14	2.6.4 See also Sections 2.2.2.2 & 2.4.2.2	The current referral form be modified to include a summary of risks identified as the basis for any previous admissions to secure care.	i. The *Policy on Children Entering Secure Care* states that *"... further admissions should not occur except in circumstances where there are new risks of the child causing significant harm to him/herself or another person or the risk of causing significant harm has not reduced."* ii. Despite multiple secure care arrangements some children continue to engage in behaviours that place themselves and others at risk suggesting it is not always an effective intervention. iii. There were 88 children with multiple admissions to secure care and 23 children had more than three admissions with one child having 20 admissions.	• Will ensure readmission to secure care is warranted on the basis of a substantially different risk than previously used as basis for admission or not significantly reduced. • Will ensure that a secure care arrangement is not being utilised as a placement option for cases that are extremely difficult to manage and in the absence of alternative placement options.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
Are there alternative options for managing the behaviour of children who are under 12 years of age				
15	2.7.4 See also Section 2.2.2	The Bilateral Schedule between Communities and Child and Adolescent Health Service (CAHS) be renegotiated to provide and promote timely health services for children admitted to KFSCC.	i. There is an absence of service models available to meet the complex health needs of young children in care. It is noted that the Mental Health Commission have publicly stated an intent to develop a specialised unit for children in care as a matter of urgency. ii. Case file reviews identified children under 12 years of age admitted to KFSCC, who require but are without a mental health professional's indication of their mental health status and needs.	• Will provide a tailored health service that is responsive to the complex needs and circumstances of children in care.
16	2.7.4 See also Section 2.3.2.6	i. Update the *Policy on Children Entering Secure Care* to include that unless extenuating circumstances exist, children under 12 years of age (who currently meet the admission criteria) should be admitted to a high support/needs placement rather than secure care - if in the best interests of the child. ii. In instances where: • a child under 12 years of age, or • a child with significant intellectual disability is admitted into secure care, that the Advocate for Children in Care is to	i. A review of trends in the age of children admitted to secure care indicates a higher proportion of younger children, below 12 years, and those with an identified learning disability, than originally intended. The secure care procedures, resources and client documents need to be appropriate for the inclusion of this unintended but growing cohort of admissions. ii. The intent of secure care as outlined in Parliamentary speeches and the current admission policy which states "... secure care is intended for children aged 12 to 17 years of age".	• A reduced number/frequency of admissions to secure care that are under 12 years of age. • In order to meet the requirements of the Act in terms of providing notice to children with regard to their rights as per section 88C and section 88F.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
		make contact with the child within 48 hours. iii. A review of the current secure care materials and procedures (e.g. admission materials, their rights and procedures necessary for review, etc.) be undertaken so as to guide the modification, or development of supplementary materials, for younger children and those with learning difficulties.	iii. The ability for children under the age of 12 years, and those over 12 years with developmental delays and/or neurodevelopmental disorders, are likely to experience limitations to fully comprehend and if desired, exercise their rights of appeal under the current Act in the absence of advocacy.	
Is the physical environment fit for purpose to manage operational performance requirements				
17	2.8.4	Communities to consider as a priority, the reconfiguration/establishment of: • a dedicated admissions entrance and triage room for children being admitted into the facility; and • a meeting room from which video conferencing can occur without the child having to access the relevant room via the working/office area of KFSCC Management and administration area.	i. Lack of a separate entry and "Admissions Room" ii. The layout of the KFSCC building has limited common passage access creating challenges during critical incidents including restraint and transfer to safe room iii. The video conference equipment is housed within a meeting room in the management and administration section. Accordingly, use of video conferencing requires children to access the relevant room via the working/office area of management and administration personnel. This represents a risk.	• Enables children to be admitted into the facility via a secure and appropriate entrance - which in turn provides a "fit for purpose" admissions room. • Avoids other children being disrupted as a result of having to vacate the outdoor area, lounge areas etc. when an admission occurs. • Video conference area – Addresses a risk issue of children accessing management and/or administration areas within the

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
				facility.
Is there sufficient oversight in place				
18	2.9.4 See also Section 3	i. That the assessment of KFSCC be conducted in accordance with a comprehensive monitoring/standards framework. ii. The Evaluation notes and supports Recommendation 23 of the Statutory Review that suggested assessment be undertaken by an independent body with sufficient broad oversight powers, involve a minimum number of annual visits including unannounced visits and include Aboriginal people to assess and determine whether the specific needs of Aboriginal children in secure care are being met.	i. The absence of a formalised Monitoring and Evaluation framework and associated reporting limits the ability to comprehensively determine if or how issues identified are completed/resolved satisfactorily and from which to measure outcomes. ii. Review of Assessor Reports to date highlight their limited basis for comparison over time. iii. Many external stakeholders, especially children's advocates, raised concerns that the current oversight arrangements about a lack of independence and Communities accountability in the current Assessor model.	• Will provide for a means of comparing and tracking over time. • Will facilitate a consistent, robust and transparent oversight process of KFSCC. • Ensures the responsiveness of the KFSCC to Aboriginal children's needs. • Creates greater understanding and confidence among the community, including the Aboriginal community, about the centre.
19	2.9.4	That a protocol be formalised for the forwarding of the Assessor Reports to an external body such as Commission(er) for Children and Young People (CCYP)/Ombudsman - for review.	i. No formal process in place for Assessor Reports to be provided to CCYP/Ombudsman.	• Enhanced oversight by external body.

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
Can resources be allocated more efficiently to address service gaps in the system				
20	2.10.4 See also Section 2.4.2.2	The Evaluation supports the implementation of Recommendation 47 of The Statutory Review – s22 of the Act be amended to require a public authority prescribed in regulations to prioritise and provide services in certain circumstances.	i. Limited formalised processes that facilitates a commitment to a multi-agency response to children in care with complex needs and at extreme levels of risk. ii. General theme identified by internal and external stakeholders that there is an opportunity/requirement to achieve an enhanced level of collaboration and coordination between Communities and other relevant government agencies (as well as responsibility from other agencies towards children in care). iii. Identified barriers to agency responsiveness and collaboration include gaps in knowledge and particular views among different agencies towards each other's practices, different care models and responsibilities; limited and differing allocation of resources impacting on capacity for collaborative practice.	• Will formalise agencies requirement to respond and be responsible for relevant needs of children in care and those exiting secure care. • Supports a culture of shared decision making and responsibility between relevant government agencies, external organisations and Communities with regard to children in, and transitioning out of, secure care.
21	2.10.4 See also Section 2.7.2.6	Communities convey to the Mental Health Commission / Department of Health the importance of prioritising the development of a specialised children in care mental health program as outlined in the *Western Australian Mental Health,*	i. No specialist services currently exist for young people in OoHC despite recurrent findings showing high rates of mental health needs. ii. A review of the referrals and needs analysis tools indicates a high prevalence of young	• A more tailored response applied to children in care with complex needs and reflects good practice from the United Kingdom (UK).

Rec. #	Report Section	Recommendation	Key findings that underpin/support the Recommendation	Impact of the Recommendation (what benefits will it provide/result in)
		Alcohol and Other Drug Services Plan 2015–2025.	people entering secure care with mental health needs.	
22	2.10.4	That a protocol/MOU be established between Communities and Department of Justice that formalises and specifies the relevant information to be exchanged between the parties so as to assist in the effective transition of relevant youth between KFSCC and Banksia Hill Detention Centre (and vice versa).	i. General feedback from stakeholders that enhancements are required regarding the timely exchange of information between Communities and Department of Justice.	• Enhanced collaborative practices regarding the continuum of care.

1 Introduction

This report provides the findings and recommendations of an evaluation of the Kath French Secure Care Centre (KFSCC).

The Evaluation has considered the following areas of focus:

- the service model and whether it is appropriate to meet the intention of the KFSCC
- actual operations at the KFSCC
- outcomes and effectiveness of the KFSCC
- alternative options for young people and comparison to approaches in other jurisdictions
- the allocation of agency resources towards the intervention model.

1.1 Background

The KFSCC commenced operations in May 2011 and is Western Australia's (WA) first secure care facility staffed by a multidisciplinary team where children are provided with up to 21 days of intensive support (and one possible extension of up to a further 21 days). The KFSCC offers a planned, short-term intensive trauma-informed intervention for children and young people aged 12-17 years of age. In exceptional cases, children under 12 years of age who are at extreme risk and where existing services cannot manage the risk can be admitted to the KFSCC. The centre is intended to provide some of WA's most vulnerable children in out of home care (OoHC) with their best opportunity to stabilise and begin to address the complex problems and behaviours that prevent them from maintaining longer term placements and, where appropriate, transitioning to more independent living.

1.1.1 Establishment

The Ombudsman of Western Australia's Report on *Allegations Concerning the Treatment of Children and Young People in Residential Care* (2006) and Prudence Ford's subsequent review of the then Department for Community Development (2007) both identified the need for a secure care facility for children in care in Western Australia. Ford recommended a 3-tiered system of residential care and noted the need for an evidence based therapeutic model, staffing model and competency-based training reflecting the therapeutic nature of the services. Ford recommended that the Kath French facility[6] become the third-tier as an intensive therapeutic unit for a small group of children and young people in care aged 12-17 years at very high risk of self-harm or significant risk to those around them.[7]

1.1.2 Parliamentary processes

The Children and Community Services Act Amendment Bill (2010) sought to introduce "a suite of amendments to improve and strengthen the operation of" the *Children and Community Services Act*

[6] The Kath French Centre was opened in 1999 to offer assessment and planning for vulnerable and troubled young people who demonstrated very complex high risk behaviours to themselves and/or others.

[7] Department for Child Protection and Family Support (2016). Review of the *Children and Community Services Act 2004*: Consultation Paper. Perth, Western Australia, p.27.

2004 (CCSA).[8] Two major new developments outlined in the legislation were the establishment of a secure care facility for children and young people at extreme risk, and the introduction of special guardianship orders for children who were unable to live permanently in the care of their own families.

In the Bill's Second Reading speech, the Parliamentary Secretary noted the need for a secure care facility had "long been deliberated" in WA. He suggested the model introduced in the Bill was largely based on Victoria's model.[9] The Parliamentary Secretary was at pains to point out a secure care facility was to be an "***an option of last resort for managing the highest levels of risk that some young people***" present. It was to be used only when the "CEO or the Children's Court is satisfied that a child meets the highest threshold of being ***at substantial and immediate risk of causing significant harm to himself or others, with no other way to manage that risk and ensure that he receives the care that he needs.***"[10]

The secure care facility was not intended to be used for punitive purposes, or as an alternative to providing psychiatric care, but rather, "***to stabilise young people and keep them safe while developing a suitable plan to address their needs and return to the community. A multi-agency response can assess complex needs and ensure that transition plans are developed, and services provided to support the child's return to a suitable placement.***" As an option of "last resort" a young person was to be kept in secure care for "***the shortest [period] necessary to stabilise the child***", with the Bill allowing for a secure care period of up to 21 days, with a further 21 days possible in "exceptional" circumstances.[11] The aim, as described in the Bill's Explanatory Memorandum, was to "***ensure children are protected from prolonged periods of time kept under a secure care arrangement.***"[12]

The Explanatory Memorandum also described that amendments to the CCSA sought to ensure the principle of child participation in decision making would apply to children under a secure care arrangement by making it clear that decisions about secure care arrangements were among those decisions likely to have a significant impact on a child's life.

As in the Second Reading speech, the Explanatory Memorandum stressed that "children are placed in the secure care facility as a measure of last resort only, once it has been determined that there are no other suitable ways to manage the situation", furthermore, that a "secure care arrangement is a therapeutic rather than punitive option"[13].

1.1.3 Legislative requirements

The amendments to the CCSA were introduced to address the needs of a small but increasing proportion of children aged 12 – 17 years in the care of the Chief Executive Officer (CEO) of

[8] Western Australia, Parliamentary Debates, Legislative Assembly, 22 June 2010, Mr A. J. Simpson, p4236c-4238a

[9] Western Australia, Parliamentary Debates, Legislative Assembly, 22 June 2010, Mr A. J. Simpson, p4236c-4238a

[10] Western Australia, Parliamentary Debates, Legislative Assembly, 22 June 2010, Mr A. J. Simpson, p4236c-4238a

[11] Western Australia, Parliamentary Debates, Legislative Assembly, 22 June 2010, Mr A. J. Simpson, p4236c-4238a

[12] Explanatory Memorandum, Children and Community Services Amendment, 2010 (Western Australia). p.5.

[13] Explanatory Memorandum, Children and Community Services Amendment, 2010 (Western Australia). P.4

Communities who present a substantial risk to themselves and/or others, and require immediate stabilisation, assessment and support.

The majority of the secure care provisions can be found in sections 88A to 88J of the Act and include the threshold for admission to secure care; how children may be admitted; the length of time they may stay; and the planning requirements. The Act also provides safeguards which:

- require court orders for children under the provisional protection and care of the CEO;
- enable applications to be made to the State Administrative Tribunal for a review of the secure care arrangements of children who are in the CEO's care under a protection order (time limited) or protection order (until 18); and,
- allow for the appointment of an Assessor with powers which include being able to enter and inspect the facility and talk to children in the facility (see section 125A).

Further fundamentals of the WA secure care model outlined in the legislation include:

Only the CEO of Communities can initiate a child's admission to secure care, either through direct admission to the facility or by making an application to the Children's Court. In order to do so the CEO must be satisfied that the following criteria, from section 88C of the Act, are met:

(a) there is an immediate and substantial risk of the child causing significant harm to him or herself or another person; and

(b) there is no other suitable way to manage that risk and to support the child to receive the care he or she needs.

A child or young person admitted to the KFSCC under a secure care arrangement will be either:

- the subject of a protection order (time-limited) or protection order (until 18) (referred to as a "protected child"); or
- in the provisional protection and care of the CEO (and either already the subject of a protection application in the Children's Court or to become one within two working days of admission).

A child or young person may be admitted to the KFSCC under a secure care arrangement via an:

- administrative admission, which occurs for a protected child , or a
- judicial admission, which describes the process required for a child or young person who is in, or is taken into, provisional protection and care.

An interim order (secure care) is an order from the Court that the CEO either make a secure care arrangement for a provisionally protected child, or continue a secure care arrangement that the CEO has already made for the child (referred to as a continuation order). The Court must not make an interim order (secure care) unless it is satisfied that there is an immediate and substantial risk of the child causing significant harm to the child or another person; and there is no other suitable way to manage that risk and to ensure that the child receives the care they need. Application to the Court for a continuation order must be made by the CEO as soon as practicable and not more than two working days after the child is admitted to the KFSCC.

Under section 88F, as soon as practicable after making a secure care arrangement in respect of a protected child, the CEO must decide the period (the secure care period) for which the child is to be kept in a secure care facility under the arrangement. The secure care period must not exceed 21 days unless it is extended under subsection (3) where the CEO may extend the secure care period by not

more than 21 days if satisfied there are exceptional reasons for doing so. The secure care period cannot be extended more than once.

A protected child or young person under a secure care arrangement may seek a "reconsideration" of the CEO's secure care decision as to the decision to make the arrangement, the duration of the period of the arrangement or a decision to extend the period, under section 88G of the Act. They will be assisted to comply with the requirement for a written application, as required. The child's parents / carers or any other person considered by the CEO to be significant in the child's life, may also apply for a reconsideration of a secure care decision. The CEO may then confirm, vary or reverse the previous decision.

If a young person or other applicant is not satisfied with the outcome of the CEO's reconsideration, he or she may apply to the State Administrative Tribunal for a review of that decision.

Section 88I (5) outlines the requirements for a care plan or provisional care plan for a child in secure care. These plans must identify the needs of the child in his or her transition to other living arrangements after leaving the secure care facility; and outline steps or measures designed to address those needs and to reduce the likelihood of the child being placed in a secure care facility again.

Under section 125A of the legislation the CEO may, in writing, appoint a person to be an assessor with the powers to enter and inspect the secure care facility at any time to check on the operation of the facility and the wellbeing of any child in the facility. An assessor can visit a facility and do one or more of the following:

- enter and inspect the facility
- inquire into the operation and management of the facility
- inquire into the wellbeing of any child in the facility
- see and talk with any child in the facility
- inspect any document relating to the facility or to any child in the facility.

An assessor must provide a written report to the CEO about each visit made by the assessor.

1.1.4 Staffing

KFSCC has a multi-disciplinary, coordinated team approach including a Senior Clinical Psychologist, Senior Child Protection Worker, Senior Secure Care Officers and Secure Care Officers, General Practitioner (GP) and Nurse (Refer to Appendix A.1 for further particulars of the roles and responsibilities of KFSCC personnel). The Secure Care leadership group consists of an Assistant Director and Director who manage the day-to-day operations of Secure Care, as well as develop and contribute to policies and programs directly affecting their unit. It is also acknowledged that the resource framework applicable to KFSCC operates within Communities and accordingly there are various oversight arrangements in place (e.g. Chief Psychologists, Executive Director and General Manager) within Communities.

Staff are required to undergo training that provides them with skills and knowledge to offer high quality therapeutic interventions for children and to understand the effects of trauma and abuse on brain development that results in challenging and confrontational behaviour. Secure Care Officers are described as caring for and engaging with the children to assist them to work within the individual program developed for each child. Staff Qualifications are Certificate III and Certificate IV in a Human Services discipline (such as Children's Services) or allied field of study, or an outline of equivalent

experience in working with or caring for traumatised and abused children. Secure Care Officers training includes therapeutic crisis intervention, which provides knowledge and strategies to avoid behavioural escalations from children whose behaviour can often be volatile, as well as the capacity to take physical control as an ultimate safety measure to prevent children from harming themselves or others.

Senior Secure Care Officers oversee the interactions that Secure Care Officers have with children and are a critical part of the initial assessment of a child's presentation once they have entered secure care, and in developing and implementing their therapeutic and safety plans. They also work directly with children, where they provide a high standard of trauma informed therapeutic care.

KFSCC is staffed during the day by one Senior Secure Care Officer and five Secure Care Officers. Night shift staffing consists of one Senior Secure Care Officer and two Secure Care Officers.

1.1.5 Service model

The KFSCC practice is guided by the Sanctuary Model[14]; a trauma-informed practice model that is based on knowledge and understanding of the effect of trauma on development and minimises the risk of re-traumatising. The Sanctuary Model aims to create an organisational environment in which there is an understanding of the impact of trauma on individuals and families. This knowledge is embedded in all policy and procedures and interventions. This model aims to develop an organisational culture that:

- recognises children have suffered a variety of traumatic experiences;
- encourages staff to teach important skills, but also model those skills in their interactions with children;
- develops a common understanding of the reasons behind behaviour, rather than simply responding to the behaviour itself;
- provides extensive training to develop common understandings of children's challenges;
- emphasises the importance of shared goals and the creation of a philosophical framework in which these goals can be achieved;
- utilises conflict resolution strategies to support a non-crisis based and non-reactive service of care; and,
- engages staff in continual reflective practice.[15]

1.1.5.1 Trauma Informed Organisational Culture

The Sanctuary Model emphasises seven dominant cultural characteristics required to develop an organisational culture that is committed to addressing trauma. These are:

1. non-violence: building safety skills;
2. emotional intelligence: helping to teach effective management skills;
3. inquiry and social learning: building cognitive skills;
4. shared ownership: helping to develop skills of self-control, self-discipline, and the administration of healthy authority;

[14] The culture and operational philosophy of the therapeutic care services of the Department of Communities, including the KFSCC, is underpinned by the Sanctuary Model® and principles.
15 Bloom, S. L. (2013). The Sanctuary Model. Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models, 277-294.

5. open communication: helping to overcome barriers towards healthy communication, the reduction of 'acting -out' behaviours, the improvement of self -protection and self-correcting skills, and the creation of healthy boundaries;
6. social responsibility: rebuilding social connections, establishing healthy attachment relationships;
7. growth and change: restoring hope, meaning, and purpose to empower positive change.

1.1.5.2 Recovery Approach

The Sanctuary Model provides the S.E.L.F. framework - a trauma-informed tool to help staff and children and young people move through four critical stages of recovery. It incorporates the following elements:

Safety:	Attaining safety for oneself, for others and the creation of a safe environment overall
Emotions:	Examining personal experiences and developing impact management skills
Loss:	Feeling grief and dealing with personal loss
Future:	Bettering future outcomes by trying out new roles and practicing ways of relating in order to ensure personal safety and to help others.

Central to the effectiveness of the Sanctuary Model is the importance of evaluation in order to demonstrate an organisation's ability (or inability) to make positive changes.

Nine indicators are utilised to guide the evaluation of progress:

1. Less violence (physical, verbal and emotional);
2. A greater understanding of the impact of trauma within the system;
3. Less victim blaming, including fewer punitive or judgemental responses to behaviour;
4. Clearer and more consistent boundaries with higher expectations (linked to rights and responsibilities);
5. Earlier identification of perpetrator behaviour, plus appropriate strategies to deal with this;
6. Enhanced ability to state clear goals, create strategies for change, and to justify the need for a holistic approach;
7. Better understanding of repeat behaviours and resistance to change;
8. A more democratic environment at all levels;
9. Better overall outcomes for children and young people, staff, and the organisation.[16]

1.2 Purpose of the evaluation

This Evaluation aimed to address some of the *Statutory Review of the Children and Community Services Act 2004* ('Statutory Review') recommendations relating to KFSCC that were tabled in the Parliament of WA in November 2017, and to consider the broader service system impacting on children with

[16] Bloom, S. L. (2005) The Sanctuary Model of Organizational Change for Children's Residential treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations. 26(1): 65-81.

extremely complex needs. This includes investigating the effectiveness of KFSCC as a protective intervention for children and identifying recommendations relating to the delivery of services for young people with complex needs, the secure care model, and legislative policy into the future.

The Statutory Review included eight recommendations on secure care provisions, six of which were considered in the Evaluation design. The remaining two recommendations relate to amendments to the CCSA and, accordingly, are not within the scope of the current Evaluation.

The six recommendations subject to this Evaluation are:

Recommendation 19 - The maximum timeframes in which a child may be placed in secure care under a secure care arrangement or an extension of a secure care arrangement should remain the same. Any amendments should be informed by an evaluation of secure care.

Recommendation 20 - Communities should examine the current barriers to transitioning children effectively and safely from secure care and ways these barriers can be addressed.

Recommendation 21 - The target age-range for admission to secure care should continue to be children aged from 12 to 17 years and the admission of younger children should be avoided where possible.

Recommendation 22 - Work is urgently required to examine alternative means for addressing the complex needs of a small but increasing number of children aged younger than 12 years who, in the absence of suitable alternatives, are being admitted to secure care.

Recommendation 23 - Rather than the assessor model in section 125A of the CCSA, under which the Chief Executive Officer (CEO) is responsible for the appointment of assessors, oversight of Communities secure care facility should:

- be undertaken by an independent body with sufficiently broad oversight powers
- involve a minimum number of annual visits including unannounced visits
- include Aboriginal people to assess and determine whether the specific needs of Aboriginal children in secure care are being met.

Recommendation 24 - An evaluation of the role and effectiveness of secure care as a protective intervention for children should be undertaken as soon as possible to inform secure care practice and legislative policy into the future, including informing the optimal time frames required for stabilising and assessing the needs of children admitted to secure care. The evaluation should contribute to the development of an ongoing monitoring and evaluation framework aimed at building evidence-based continual improvements.

Aligned with these Statutory Review recommendations, the following Evaluation Questions are assessed:

i. explore the comparability of secure care services in other jurisdictions, including international models

ii. examine the extent to which the KFSCC is operating as intended

iii. provide evidence on the role and effectiveness of secure care as a protective intervention for children

iv. consider the appropriateness of the admission criteria and service model in identifying and responding to children in care with extremely complex needs

v. identify the availability of alternative options to manage the behaviours of children under 12 years of age who have been held under a secure care arrangement

vi. examine the current barriers to transitioning children safely from the KFSCC

vii. identify intended and unintended outcomes for children admitted to the KFSCC, their families and carers

viii. determine if the building is fit for purpose to manage operational performance requirements

ix. examine the appropriateness of oversight arrangements, including the assessor model

x. identify service gaps and the allocation of resources across government to meet the needs of, and improve outcomes for, children with complex needs.

Based on the findings of the Evaluation, an ongoing monitoring and evaluation framework for the KFSCC has been developed (refer Section 3). The framework enables ongoing systematic monitoring of the service and includes indicators, data sources, frequency of data collection, responsibilities and planned reporting timelines.

1.3 Evaluation methodology

The method of evaluation is summarised below with further details available in sub-section 1 of each evaluation question. The data and information used to inform the Evaluation and address the evaluation questions included the following:

- a comprehensive Literature Review – Refer to Appendix B
- a Desktop Review of policies and procedures applicable to the KFSCC and relevant reports
- extensive stakeholder interviews consisting of external agencies/NGOs, Communities internal stakeholders and a selection of young people who had been admitted into KFSCC and their carers/family members
- feedback forms completed by young people exiting KFSCC (n=168)
- survey of KFSCC staff (n=18 complete responses; 8 partial responses)
- review of ASSIST[17] client data associated with young people admitted into the KFSCC since commencement in May 2011 to April 2018 (n=219 distinct children and 418 secure care admissions)
- analysis of 17 approved referrals for admission in the six month period prior to the commencement of the Evaluation
- a selection of case file reviews extracted from *Objective* database[18] (n=30 with 12 under 12 years at first admission, 11 with multiple [three or more] admissions, six with identified disability and eight who were individually interviewed); it is important to note that as the file reviews undertaken by the Evaluation were not a random sample (i.e.

[17] ASSIST is a database of client information maintained by Communities

[18] *Objective* is a searchable document repository maintained by Communities.

chosen because they were under 12 years on admission, multiple admissions etc.) they are not generalisable to the population of secure care admissions)

- Approved referral forms reviewed (n=81) and approved extensions reviewed (n=51)
- a site visit to Secure Welfare Services in Victoria
- a comparison exercise between an overseas secure care facility (The Good Shepherd Centre - Scotland), the Victorian Secure Welfare Services and the KFSCC (see Appendix A).

Following is an overview of the number of stakeholders consulted by category (refer to Appendix C for further information on stakeholders consulted).

Table 1-1: Stakeholders consulted

Stakeholder cohort		Total Count
External agencies/ NGOs		18
Communities internal stakeholders		38
Family and carers		2
Young People	In KFSCC	6
	Post KFSCC	9
	Male	6
	Female	9
	Aboriginal	3
	Non-Aboriginal	12

2 Evaluation Questions

2.1 How are secure care services in other jurisdictions implemented?

2.1.1 Method

The examination of secure care services in other jurisdictions was conducted via desktop assessment using available research, reports, legislation, Parliamentary Hansard, websites, and publicly available secure care documentation.

2.1.2 Findings

2.1.2.1 Legislative Provisions for secure care in Western Australia

The legislative provisions for secure care in WA have been discussed in Section 1.1.3.

2.1.3 Secure care in Australian jurisdictions

The literature (and desktop) review assessed secure care models in Australia (primary jurisdictions being New South Wales (NSW), WA and Victoria) investigating:

i. Policy and legislation.
ii. Service model approach– criteria, length of stay.
iii. Review procedures and oversight arrangements.
iv. Staffing and case management.

Along with WA, both NSW and Victoria have secure care facilities for children under child protection orders. The aims of all the secure care facilities are containment and safety, assessment and provision of a therapeutic environment with differing implementation models applied to achieve these aims. In all three jurisdictions the point of intervention at which a child is referred to secure care involves children considered at extreme risk. The admission criteria and point of intervention is not for children requiring a mental health facility or because of a criminal activity.

Some of the differences between WA, NSW and Victoria relate to the way that placement in secure care is initiated, the oversight of the placement, the length of time that a child can remain in secure care and the review and reporting requirements. One critical difference is that, unlike Victoria and WA, the admission of children to secure care is not provided for in legislation in NSW. There is limited evidence available assessing the effectiveness of any of these facilities.

The following seeks to compare and further explore the components of secure care facilities and approaches in NSW, Victoria and WA.

2.1.3.1 Criteria

Currently across all the jurisdictions with secure care facilities in Australia, there is a clear distinction between secure care and youth detention, with admission criteria that excludes the admission of children via a court decision on criminal charges. Application for a child's placement in secure care is based on an identified substantial and significant risk to the child where such an intensive level of protection is deemed the only suitable option for ensuring their safety and wellbeing. Placement in a secure care facility generally involves containment and a restriction of a child's or young person's

liberty on the grounds that this is in their best interests. The intended age of children admitted to secure care range from between 12 and 17 years in NSW, 10 to 17 years in Victoria, and 12 to 17 years in WA. In WA and Victoria, the intended ages for secure care are not provided in the legislation, rather it is a matter of Department policy. All three jurisdictions have admitted children younger than 12 into secure care.

Victoria

Victoria's secure care – Secure Welfare Services (SWS) - is overseen by the Department of Health and Human Services (DHHS). Secure care is currently provided through two 10-bed, gender specific secure facilities[19]. The *Children, Youth and Families Act* (the CYF Act) *2005* defines a SWS as a "community service that has lock-up facilities"[20]. Secure care is to be used only as an option of last resort where all other placement and support options have been considered and cannot provide the child with adequate protection from significant harm or reduce the risks to, or posed by, the child.[21] The following three criteria must be met before authorisation for a placement at SWS is sought:

- placement at the SWS is in the young person's best interests. This means that explicit consideration of the young person's safety and developmental needs demonstrates that placement at the SWS is necessary, and
- there is substantial and immediate risk of harm to the young person and no other available support or placement is adequate to protect the young person from significant harm, and
- contact has been made with the SWS to confirm that a place is available and that the identified needs of the young person can be met.

Children aged 10 to 17 years subject to a 'family reunification order', a 'care by Secretary order' or a 'long-term care order' may be placed in SWS subject to approval of the Area Operations Manager or Assistant Director, Child Protection or a more senior officer. In exceptional circumstances, children under the age of ten years may be admitted to a SWS subject to the approval of the Area Director, or Director, Child Protection in the child's division.

There are two avenues through which children can be placed in SWS. If a young person is not on a protective order, they are admitted through a 'Children's Court Interim Accommodation Order'. A child taken into emergency care may be placed in a SWS, if there is substantiated and immediate risk of harm to the child, until the matter is brought before the court or a bail justice. The SWS is responsible for the day-to-day protection and care responsibilities for children placed there.[22]

Under the CYF Act children already under an order, the Secretary of DHHS approves an application if satisfied that there is substantial and immediate risk of harm (the equivalent of WA's administrative admissions for protected children). As with WA, there must be a court application/order if the child is

[19] Consultation with the DHHS confirmed that the exact date of secure welfare services as they currently exist is difficult to determine as the current facilities have existed prior to the current arrangements and were previously used for the containment of at risk children and young people in both a youth justice and welfare context. The Ascot Vale facility has been in existence since the mid-1990s and the Maribyrnong facility was built in 2002. The facilities are said to have "gradually" transitioned to their current provision of care.

[20] Children, Youth and Families Act 2005, (Vic) Act No. 96/2005, p15

[21] Victoria, Department of Health and Human Services, retrieved from http://www.cpmanual.vic.gov.au/policies-and-procedures/out-home-care/secure-welfare/secure-welfare-service-placement

[22] See fn[21]

not already in the care of the CEO. The CYF Act sets out that the Secretary (DHHS) may deal with a child in a number of ways, including by placing:

> him or her in a secure welfare service for a period not exceeding 21 days (and, in exceptional circumstances, for one further period not exceeding 21 days) if the Secretary is satisfied that there is a *substantial and immediate risk of harm to the child*.[23]

Section 75 of the CYF Act states that if a child is placed in a secure welfare service the Secretary is required to plan for, and support, the transfer of the child to, and integration of the child in, another suitable placement to reduce the likelihood of the child being placed in a SWS again.

New South Wales

In NSW, secure care is overseen by the Department of Family and Community Services (DFaCS). Secure care is not legislated, and placement of a child in secure care is via a Supreme Court order sought by the Director of DFaCS. The Supreme Court has responsibility for determining whether or not a 'therapeutic secure care order' is made which is subsequently approved by the Deputy Chief Executive, DFaCS. The Supreme Court makes interim therapeutic secure care orders only, sets review dates and issues instructions to the Department about the information to be provided at the next review.

Secure care is currently provided at Sherwood House, a residential facility with the capacity to restrict children's outside movement when required as part of the therapeutic response. There are two semi-secure cottages that provide different levels of containment as part of a step-down model. Operation of Sherwood House commenced in 2010 and is the only secure therapeutic residential secure care facility in the state. The facility provides secure care almost exclusively to girls, although it does accept referrals for boys. Sherwood House has the capacity to accommodate 12 young people. Since it was established, 45 children have been at the secure care facility.

2.1.3.2 Length of Stay

In WA, the maximum (without extension) length of stay/secure care arrangement is 21 days and this duration is determined within 48 hours of the child's secure care admission. The secure care period can be extended under section 88F(3) of the CCSA whereby the CEO may extend the secure care period by not more than 21 days if satisfied there are exceptional reasons for doing so. The secure care period cannot be extended more than once. The secure care arrangement for a protected child may also be cancelled by Executive Director (as the CEO's delegate) following a briefing rationale.

In Victoria the secure care arrangement may be made for up to a maximum of 21 days (the secure care period). In exceptional circumstances, the period at a SWS may be extended for one further period not exceeding 21 days. This does not mean that there cannot be subsequent placements of a child in a secure care facility. The purpose of secure care is designed to be an emergency/short-term option where the containment of a child is designed to reduce the child's risk of harm, be strictly time-limited and used to develop or revise the plans for the child's return to the community. This may include referral to other longer term therapeutic programs, placement and support services. Currently the average length of stay in Victoria is nine days. There is also a procedure for when secure care centres are at, or near, capacity that influence the length of a secure care arrangement.

[23] *Children, Youth and Families Act 2005* (Vic), s173, p.110 [emphasis added]

In NSW a seven-day order is usually initially obtained from the Supreme Court to allow for adequate assessment of the child and to make further application to the Supreme Court. If satisfied, the Court then grants a three-month order. Orders are reviewed every three months by application to the Supreme Court. Further applications to the Court must be made every three months to satisfy the Court that the criteria for secure care continue to be relevant. The average length of stay in secure care in NSW is between 16 – 24 months.

2.1.3.3 Review Procedures

All Australian jurisdictions providing secure care have appeal and review processes in place. In WA, a protected child under a secure care arrangement may seek a "reconsideration" of the CEO's secure care decision under section 88G of the CCSA, namely: the decision to make the arrangement; the duration of the secure care period; and the decision to extend the period. The child's parents / carers or any other person considered by the CEO to be significant in the child's life, may also apply for a reconsideration. The CEO may then confirm, vary or reverse the previous decision. In the event that a young person or other applicant is not satisfied with the outcome of the CEO's reconsideration, he or she may apply to the State Administrative Tribunal for a review of that decision.

In NSW, reviews are judicially based. In Victoria, as in WA, a person affected by a decision to place (or to not place) a child or young person at, or to exit them from secure care (i.e. a parent, carer or child) may first request an 'internal' review. Decisions that can be reviewed include the decision to make a secure care arrangement for the child, length of the secure care period or the decision to extend the secure care period by not more than 21 days if there are exceptional reasons for doing so. A person significant to the child, including a child or young person, may request a review of the length of time a child or young person is proposed to be placed at the SWS. Area Directors of DHHS are authorised to review case planning decisions including SWS placement decisions. Applications for review regarding children and young people placed at SWS are heard by an officer senior to the one who approved the admission. A review of a SWS placement decision should be determined within two business days of being received by DHHS. In certain circumstances, parties within Victoria may have casework decisions reviewed by the Victorian Civil and Administrative Tribunal.

2.1.3.4 Oversight

Mechanisms for overseeing the activities of secure care facilities include monitoring through oversight reporting and complaints mechanisms, community visitor programs and process evaluation strategies such as child/youth satisfaction surveys. Oversight arrangements vary.

In WA, section 125A of the CCSA provides for assessors who may at any time, visit a facility and do one or more of the following:

> (a) Enter and inspect the facility.
>
> (b) Inquire into the operation and management of the facility.
>
> (c) Inquire into the wellbeing of any child in the facility.
>
> (d) See and talk with any child in the facility.
>
> (e) Inspect any document relating to the facility or to any child in the facility' (s3).

In Victoria there is no oversight process for SWS provided for in the CYF Act.

In NSW, each child in secure care has an active case with the Supreme Court that involves three-monthly hearings and associated reporting requirements. The secure care facilities are also visited regularly by the Official Community Visitor – managed by the NSW Ombudsman Office. The secure care facility is also accredited by the Office of the Children's Guardian. Records of practice relevant to the safety, welfare and wellbeing of children and young people at Sherwood House must also be made available to the Children's Guardian for inspection upon request, in written form or an electronic format. Furthermore, the Office must receive written notification every time a child under 12 years of age is placed in residential statutory OoHC including the state's secure care facility.[24]

Both Victoria and WA have children's commissioners who can visit the secure care facility, currently these visits are negotiated between Communities, the respective Commissioner for Children and Young People (CCYP) and Ombudsman's Office. In March 2016, amendments to the *Commission for Children and Young People Act 2012* (VIC) came into effect that require the Secretary, DHHS to disclose to the Children's Commissioner "any information about an adverse event relating to a child in out-of-home care or a person detained in a youth justice centre or a youth residential centre if the information is relevant to the Commission's functions." [25]

2.1.3.5 Staffing and Case Management

Staffing and case management arrangements within the WA KFSCC has been described in Section 1.1.4.

In NSW, the therapeutic secure care program is managed and operated directly by the DFaCS (Operations) under the direction of the Director, Intensive Support Services (ISS). ISS oversees the secure care facility and an intensive case management team. Here children with the most complex needs and high-risk levels across the state are intensively case managed by highly skilled caseworkers with a maximum caseload of six. An independent Clinical Director is appointed to oversee the therapeutic aspects of the program and ensure independent clinical advice.

The clinical program design, client case formulation, behaviour support planning and staff training at Sherwood House are contracted through a private agency (fee for service). The carers in the program are contracted from non-government personnel management agencies working in the youth work sector. While staff members are contracted from agencies, they work at Sherwood House as permanently rostered staff. Sherwood House is staffed during the day by four carers, one House Manager and one Manager with one carer during the night shift. The centre also employs four security staff per shift who have a 'watching brief' or line of sight role with the aim of providing rapid de-escalation by firstly escorting the child away or, if necessary, the use of a sitting or standing restraint. Sherwood House does not utilise seclusion with critical incidents (there is no safe room in Sherwood House).[26]

In Victoria, staffing arrangements for the two secure care facilities comprise a Team Leader and five Secure Care Officers for the day shift and a night shift comprising two Secure Officers to each Team Leader. Cultural Support Workers are available to support young people in SWS from Aboriginal and culturally and linguistically diverse backgrounds. Minimum staff qualification for Secure Officers is Certificate IV in Youth Work. New staff undergo a two-week induction process comprising: four

[24] Office of the Children's Guardian, NSW. Notice of Conditions of Accreditation as a Designated Agency. Community Services Sherwood House. Issued under Clause 65 of the Children and Young Persons (Care and Protection) Regulation 2012

[25] Child Wellbeing and Safety Amendment (Oversight and Enforcement of Child Safe Standards) Act 2016. No. 63 of 2016. Part 4—Amendment of the Children, Youth and Families Act 2005.

[26] Personal communication with Assistant Director, ISS, DFaCS, NSW

"shadow shifts"; three "classified" days; two days in preventing occupational violence and one day of therapeutic in care training. Psychology services are outsourced to an organisation contracted to provide consults to 100 youth per annum (approximately 3 to 4 per week). The health services provided at both secure facilities are delivered by the Youth Health and Rehabilitation Services. The Service comprises a General Practitioner, Clinical Nurse Manager, General Nurse and Psychiatric Nurse working collaboratively with SWS staff to provide a "wrap- around" service for the young person.

2.1.4 International comparisons

Many of the models of secure care detailed below use secure care on welfare grounds and within a juvenile justice context – meaning that children can be placed into secure care as a result of concerns for their welfare or on the basis of offending.

New Zealand

New Zealand has four secure care facilities – referred to as care and protection secure residences. There are several distinct client types in the care and protection secure residential population:

- females
- child offenders (< 13 years) both with current and previous offences
- young care and protection children (≤ 12 years)
- children and young people with significant trauma and neglect histories.

For admission into secure care, all children and young people must be under the care, custody or guardianship of the Chief Executive of the Ministry of Social Development. The two most common legal statuses of young people admitted to care and protection secure residences in New Zealand are s101 (custody order) and s78 (custody of child or young person pending determination of proceedings). On admission, the two most common statuses for young people were s101 (custody order) and s78 (custody of child or young person pending determination of proceedings) orders. From 2010 to 2014, 73 per cent of young people admitted to a secure care and protection residence had s101 custody orders. The average stay in a care and protection secure residence is 136 days, with a downward trend in duration over time.[27]

Ireland

In Ireland, secure care, known as special care units, are secure, residential facilities for children in care aged between 11 and 17 years. Special care units are prescribed as 'designated centres' in the *Health Act 2007* (as amended by the *Child Care (Amendment) Act 2011*).

The *Child Care (Amendment) Act 2011* established special care on a statutory basis and defined special care as the provision of care to a child which addresses:

- his or her behaviour and the risk of harm it poses to his or her life, health, safety, development or welfare
- his or her care requirements and includes medical and psychiatric assessment, examination and treatment and educational supervision.

[27] Lambie, I. (2016) Care and Protection Secure Residences: A report on the international evidence to guide best practice and service delivery. Published May 2016 Ministry of Social Development, Wellington, New Zealand

Special care is said to be part of a continuum of State care available to children in Ireland. It provides for a short-term, stabilising intervention that prioritises safe care in a secure, therapeutic environment. It aims to enable the child to return to a less secure placement as soon as possible, based on the needs of that child.[28]

Receipt of an intervention in a special care unit can only be made in accordance with an Order of the High Court under provisions made in the *Child Care (Amendment) Act 2011*. Referrals for special care are made by the Child and Family Agency (known as Tusla) using approved procedures, which include social work referral to the Special Care Referral Committee.

Following approval for placement in special care, an application is made to the High Court for a special care order or an interim special care order. Interim special care orders may be made before the normal procedure for a special care order is complete. Such orders will mean that the child may be detained in a special care unit for up to 28 days. Where a child in special care is already subject to a care order, the provision of special care takes precedence for the duration of the special care order. A special care order means that the child is committed to Tusla's care for as long as it remains in force. It authorises Tusla to provide appropriate care, education and treatment and, for that purpose, to detain the child in a special care unit. The order will initially be for a period between 3 and 6 months and may be extended. Special care orders may be varied by the court on its own initiative or by request of Tusla. The court may make a supervision or care order in respect of the child if appropriate. An application is made for an extension to the special care order when:

- a special care order is due to expire and where it is considered that a child is benefiting from special care intervention, or
- where assessments identify a continued risk of harm due to behaviour and there is a clear therapeutic rationale for the ongoing detention of the child in special care.[29]

Children in special care units are not there *because* they have committed a criminal offence. The special care unit detains children for their own care and welfare through the provision of a controlled and safe environment. Detention in special care is deemed a measure of last resort and evidence must demonstrate that the special care intervention will provide therapeutic value to the child.

The Health Information and Quality Authority (the Authority) is legally responsible for the monitoring, inspection and registration of all special care units for children in Ireland. The Authority aims to promote progressive improvements in quality and safety of care using Outcome-based Standards as a framework for the ongoing development of child-centred residential services for children. The Standards also provide children and their families and or representatives with a guide as to what they can expect from special care units.[30]

Regulation aims to provide assurance to the public that the service is fit-for-purpose and that children living in designated centres are receiving care and interventions that meet the requirements of the Standards, which themselves are underpinned by regulations. When a designated centre does not meet the required standards and or the provider fails to address the specific areas of non-compliance, then enforcement action is taken, to either control or limit the nature of the service provided, or to cancel a centre's registration and prevent it from operating.[31]

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[28] http://www.caab.ie/Functional-Areas/Special-Care/What-is-special-Care.aspx

[29] https://www.tusla.ie/uploads/content/National-Standards_Special-Care-Units-2015.pdf

[30] https://www.hiqa.ie/guidance-providers/childrens-services/special-care-units

[31] https://www.hiqa.ie/guidance-providers/childrens-services/special-care-units

Monitoring of compliance is a continuous process using set business rules, operating procedures and tools, all of which make up the assessment framework and include;

- inspection
- review of action plans
- review of notifications
- management of unsolicited information and secondary information received (media, other professional bodies)
- assessment of risk.

These procedures and tools ensure that the functions of the Chief Inspector are carried out in a consistent manner and are guided by agreed principles rather than reliant on subjective judgment. Each member of the children's inspection team is trained to undertake regulation-based inspections. During inspections, attempts are made to speak with as many children as possible, and with their families and or other important people in their lives. Inspectors also speak with staff members, the person in charge and the person who represents the provider service.

Inspection reports are typically published on the Authority's website. In some cases, reports may not be published due to the potential for identifying children, particularly in a small residential centre. Whether a report is published or not, Tusla and the service provider will receive a copy of the report, which can also be made available to children living in the centre and or their families.

Scotland

There are two methods by which young people in Scotland can be placed in secure care:

- Referral to the Children's Hearings System resulting in a Compulsory Supervision Order.
- Committing an offence and being given a custodial disposal by the Court.

In Scotland, the *Children's Hearings (Scotland) Act 2011* provides the legal oversight, including specific conditions and the 'secure care criteria' which must be satisfied before an order with authorisation for placement in secure care is made. These criteria are:

- That the child has previously absconded and is likely to abscond again and, if the child were to abscond, it is likely that the child's physical, mental or moral welfare would be at risk.
- That the child is likely to engage in self-harming conduct.
- That the child is likely to cause injury to another person.

When a Children's Hearing issues an order, with secure authorisation, there is a second stage of decision making. The Local Authority Chief Social Work Officer and the Head of the Secure Care Centre have certain powers and duties in relation to whether the secure authorisation is implemented.

The five Scottish secure care centres (providing 90 places[32]) are not youth offender institutions, or prisons, although some young people in secure care are on remand or serving sentences for serious crimes[33]. When a young person has been found guilty, or pleads guilty, the judge, sheriff or Justice of

[32] Refer https://cycj.org.uk/wp-content/uploads/2017/10/Secure-Care-in-Scotland-for-web.pdf

[33] Gough, A. (2016). *Secure Care in Scotland: Looking Ahead – Key messages and call for action*, Centre for Youth and Criminal Justice, Glasgow

the Peace will decide what sentence is appropriate. They may defer sentencing for days or weeks, during which time the young person may be detained in secure care or custody.

In the Scottish secure care sector there has been considerable investment in developing specialist intervention services. Clinicians and qualified health and wellbeing practitioners work together across care, education and support services to ensure that there is a health care pathway, in which the individual needs of each young person are identified, properly assessed and addressed. This happens through treatment and therapeutic interventions, but also through everyone involved with the young person being aware of how to respond to them as an individual in light of their mental and emotional state. In some centres, there are highly effective 'whole system' approaches in place, ensuring that attachment and trauma-informed thinking underpins all service development, policy review and practice development, including staff supervision, training and support.[34]

Oversight functions of secure care units are provided by an independent body – the Care Inspectorate who assess the unit and report against National Health and Social Care Standards. These reports are made publicly available and also grade the effectiveness of secure care units.[35]

Scottish parliament has legislated that all young people should have a throughcare and aftercare plan covering a period of at least three months following the day of departure from secure care, to support them in the community as "children in need" under *Children (Scotland)Act 1995*". Similarly, it identifies that "a placement in secure care must be part of a planned journey through the care system". There is also, within the *Children and Young People (Scotland) Act 2014* enacted in March 2015, the provision that aftercare services for young people leaving care should provide support, defined as 'advice, guidance and assistance', to young people, including those who have been in secure care, up until their 26th birthday.[36]

United States of America

Youth justice and child protection law and practice varies hugely across the United States of America. Some States may be described as having far more progressive, psycho-social and child-centred legislative, policy and practice frameworks than others, and therefore there are many different models and approaches to the use of restricted care settings or detention and custody for children, young people and young adults.

Canada

Canadian states each have scope within the Canadian legal system for their own provincial law and policy positions in relation to use of secure/restricted settings as a response to vulnerable and high-risk youth. Depending upon the jurisdiction, secure care facilities are used for longer term criminal justice to medium term mental health treatment to shorter term crisis or substance misuse programs. There are seven provinces in Canada that have legislative provisions within their child protection legislation for the involuntary confinement of young people for the use of secure care or treatment. Two provinces have legislation outside of their child protection acts that allows for the confinement of young people misusing substances. In addition, Alberta has specific legislation that permits the

[34] Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice. University of Strathclyde

[35] The Scottish Government established the Secure Care Strategic Board in 2017 whose role includes developing a Secure Care National Standards to improve experiences and outcomes for most vulnerable young people. The Board is due to report by the end of 2018.

[36] fn [34]

confinement of young people who are being sexually exploited. Four other provinces and the three territories – Yukon, Northwest and Nunavut – do not have provisions for the involuntary confinement of children and young people except in their mental health or criminal justice legislation. As an alternative, these jurisdictions use intensive one-on-one supervision and/or confine the young person in their mental health and/or criminal justice facilities. Grant (2016) suggests that one outcome of these alternative arrangements is young people being labelled criminal or mentally ill in order to access safe and secure environments for them.[37]

2.1.5 Summary

There is little consistency in secure care models between different jurisdictions both within Australia and internationally (refer to Literature Review provided at Appendix B for further discussion). As such, there is a limit to the information that is like-for-like, whole of program/initiative and a basis for comparison. There are significant challenges in comparing models, not only due to their variations in design but also a lack of evidence to suggest that any one method is more effective than another. The outcomes for individuals transitioning out of secure care are not well researched. Furthermore, the absence of Australian national standards with regard to secure care also makes it difficult to have a basis for comparison across the different Australian jurisdictions. WA and Victoria share many similarities in design, largely because WA's secure care was modelled on the Victorian example. Differences between the two are the current average length of stay (18 days in WA as opposed to nine days in Victoria – refer to Section 2.2.2.2 for further commentary) and that in Victoria there are separate facilities for boys and girls, the provision of education and mental health services are from contracted providers and procedures for when the secure care facilities are at or near capacity. Both secure care models differ from those elsewhere in terms of the maximum period of time for a secure care arrangement permitted under their respective legislation.

2.2 To what extent is WA secure care operating as intended?

The elements of the service model considered in detail in this section include:

- Referral process, including roles and responsibilities of district child protection workers, other relevant Communities work units and KFSCC staff.
- Admission process and adherence to timeframes for children under a secure care arrangement, including the extension of a secure care arrangement.
- Arrangements for transitioning from the KFSCC.
- The profile of the children being admitted to the KFSCC, their circumstances (and behaviours) leading up to their admission, their experience in the KFSCC and transitioning and placement arrangements on exiting the KFSCC.
- Use of the Sanctuary Model and a multi-disciplinary approach in stabilising, assessing and planning for the ongoing treatment and service needs of children who require high levels of care and supervision.
- Responsiveness of the model to meet the specific needs of Aboriginal children and children with disabilities.

[37] Grant, C. (2016) *Secure Care Summary Report (Part One): Legislation*. Available at: https://www.researchgate.net/publication/308891681_Secure_Care_Summary_Report_Part_One_Legislation

2.2.1 Method

The following methods were utilised to examine the operations of KFSCC and determine the extent to which it is operating as intended.

- Document review includes: CCSA, Second Reading Speech, *Policy on Children Entering Secure Care*, KFSCC Tip Sheet, *Statutory Review on Children and Community Services Act (2004)*, *Review of the Kath French Secure Care Centre – Under 12-Year-old Cohort*, *Casework Practice Manual*, and KFSCC Assessor Reports.
- Consultation with stakeholders including District staff.
- Correspondence with KFSCC Management.
- KFSCC staff surveys.
- Children's feedback forms (completed on exit from KFSCC).
- Desktop review of relevant literature and published research.

2.2.2 Findings

The Second Reading Speech for the Children and Community Services Amendment Bill 2010 by the then Minister for Child Protection highlights the intent of the establishment of a secure care facility in WA. The Minister states that a secure care facility was to be an "an option of last resort for managing the highest levels of risk that some young people present". It was to be used only when the "CEO or the Children's Court is satisfied that a child meets the highest threshold of being at substantial and immediate risk of causing significant harm to himself or others, with no other way to manage that risk and ensure that he receives the care that he needs."

The secure care facility was not intended to be used for punitive purposes, or as an alternative to providing a psychiatric intervention and management, but rather,

> *"the aim of a secure care admission is to stabilise young people and keep them safe while developing a suitable plan to address their needs and return to the community. A multi-agency response can assess complex needs and ensure that transition plans are developed and services provided to support the child's return to a suitable placement."*

As an option of last resort, a young person was to be kept in secure care for "the shortest [period] necessary to stabilise the child", with the Bill allowing for a secure care period of up to 21 days, with a further 21 days possible in "exceptional" circumstances.[38]

2.2.2.1 Referral process

The referral process involves the following steps:

1. District staff complete an assessment of the child's needs to determine whether the child meets the threshold for a secure care arrangement under s.88C of the CCSA as set out in the Secure Care Admission Decision Making Tree.
2. District child protection workers must complete Form 742 'Referral for a Secure Care Arrangement', and provide accompanying information (care plan, provisional care plan and any other relevant assessments, including an exit plan for the child). This must be endorsed by the

[38] Western Australia, Parliamentary Debates, Legislative Assembly, 23 September 2010, Hon Robyn McSweeney, p7219b-7221a

District Director and forwarded to the KFSCC Director and Child Protection Front Desk (CPFrontDesk) email address prior to the consultation process.

3. A panel comprising the Director Secure Care, Assistant Director Secure Care, Senior Clinical Psychologist and Senior Child Protection Worker (the secure care management team) will consider the referral and determine its appropriateness against the legislative threshold as well as against other factors, such as the availability of a secure care bed. The Director of Secure Care endorses an application before sending it to an 'independent' decision maker (Executive Director, Country Services – currently the CEO's delegate). It should be noted that an approved referral is only considered to be valid for a period of seven days.

Interviews with District staff and review of the Assessor reports of the KFSCC suggest that the referral process is very tightly managed by KFSCC Management and strictly adheres to the guidelines. The *Casework Practice Manual* states that "Consultation should occur with secure care management prior to developing a referral to obtain guidance in risk threshold assessment". Interviews with District Directors confirmed referrals involve consultations with KFSCC prior to submission of the referral form and that the consultations can be of real benefit to ensuring the referral meets the threshold. A District will often inform KFSCC Management quite early about a child's behaviours once they start to identify the child might require secure care. The view from District Directors interviewed for the Evaluation was that they receive good feedback about the threshold for secure care and the likelihood or otherwise of a referral being successful.

Referral notes captured in Communities data provide some examples of the interactions between Districts and KFSCC Management. In reviewing this data, the Evaluation team noted instances where additional information was requested and supplied within one day of the initial referral; a referral was denied as the criteria was not met (the child was not at that time in the CEO's care) after which a subsequent referral was denied as the child had had only been in the current placement for three days and their risk had decreased during that time. The child entered secure care after the third referral when the child did meet the admission criteria and this occurred approximately a month after the initial referral was made. This highlights the challenges and complexities (in some instances) associated with actioning the referral process.

District staff acknowledged that the threshold for secure care is "very high" which can make the referral process challenging, especially when staff believe a child is needing secure care immediately. It was acknowledged that KFSCC Management work hard to assist the Districts, but it can take time going back and forth to refine the referral application. This process can take a full day or even overnight (according to one District Director) which, District staff admitted, can create issues when there is a child in crisis or at risk of absconding and then not being able to locate them. That said, District staff recognised the need for such rigour in the referral process because secure care is a legislative process and essentially involves the deprivation of a child's liberty.

Examination of the referral forms associated with the 81 admissions from January 2017 to April 2018 highlight that mental health risks are almost universal among the referrals (89%), substance abuse issues are also high (82%), risk to self or others is 100 per cent and immediate risk is 100 per cent. This suggests that the referrals are meeting the threshold test as outlined in the Act and Policy.

The Evaluation reviewed the 2018 admission data to 30 April to examine the time between approval of a referral to secure care and a child's physical admission to secure care. For the 16 admissions in that period, the time between referral approval and admission varied from 1 to 4 days (see Table 2-1). It is acknowledged that the admission occurred within the prescribed seven day referral approval period.

Table 2-1: Time between referral approval and admission

Number of days between referral and admission[39]	Frequency
0 days	4
1 day	5
2 days	1
3 days	2
4 days	3

The Evaluation was unable to identify the time period between a District's initial and informal approach to KFSCC Management with regard to a potential referral and the actual acceptance of a referral. The team was also unable to identify the number of potential referrals that are not progressed following a discussion with KFSCC Management.

One issue raised during the consultations with some District staff concerned the way consideration of certain factors such as a child's age, risk profile and gender along with the profile of those already at the centre, might influence the decision by KFSCC Management. Specifically, whether the centre could accommodate them at the time the referral was received. Some District staff felt that the only consideration should be whether the child meets the threshold and if there is a bed available. This view was also expressed by KFSCC Management. It is also noted that the Casework Practice Manual states that "the number of admissions and the gender balance must be carefully managed". Linked to this discussion is the matter of what should occur in instances where KFSCC is near to, or at capacity. This is particularly relevant for facilities with a limited number of beds available. It is suggested that a secure care facility should have a policy in place that provides guidance/framework in dealing with scenarios such as this. In addition, the existence of such a policy and procedures provides some transparency/accountability. Such a policy will assist in providing clarity in addressing a scenario where the facility is at capacity and yet, new and additional children meet the threshold for admission to secure care.

Those working in the regions, especially the remote areas of the state, suggest the decision to seek to refer a child to secure care is a more challenging process for a number of reasons. There is the issue of distance from the KFSCC, transportation to the centre requires the child to be stable enough to travel. In terms of transporting children and young people to secure care there is a the "Bilateral Schedule between the (former) Department for Child Protection and Family Support and Western Australian Police – Transport of Provisionally Protected and Protected Children and Young People under a Secure Care Arrangement, 2016" which was commented on favourably by KFSCC staff and metropolitan district staff. There were some concerns raised by country staff, case managers, team leaders and District Directors that transport of children with challenging behaviour could be a problem and on occasions led to referrals not being carried through as Police were not willing to assist in the transport of the child.

A second issue relates to the timing of notifying a child that they are going to secure care because of the high risks of the child absconding, coupled with the challenges of holding them while waiting to

[39] In addition to the particulars contained in Table 2-1, there was an admission into KFSCC that was originally delayed [redacted].

transport them. One District Director described the practice of timing this process as close as possible to flight times to avoid having to try and keep a child in the office or other temporary and fairly impractical measures. Removal to KFSCC is also an expensive process that comes out of the District's budget. Often a staff member and a suitable carer or family member will travel with the child to assist the process. This is a costly process with flights, accommodation and car hire in Perth to transport the child to the KFSCC and then return staff and others back to the region.

2.2.2.2 Admission process and adherence to timeframes including the extension of a secure care arrangement

The process for admission of a child to secure care is as follows:

- Referral Form and Assessment Form are sent to the CEO (or delegated authority) for approval. Therapeutic Planning documents are compiled by KFSCC Senior Clinical Psychologist (contains a Safety Plan, Trauma Profile, Medical Issues Form, Brief History and Therapeutic Response Plan).
- Once approval is received from CEO, transport arrangements commence in collaboration with District staff[40].
- Child admitted to KFSCC. Admission forms completed by Secure Care Officers. Child's medical examination is undertaken.
- Initial Planning Meeting takes place within 48 hours of the child's admission. Child's care plan is updated by the District.

Planning meetings

Three meetings take place during a child's secure care arrangement – a child's initial planning meeting, progress meeting and exit meeting. The KFSCC Director, Assistant Director, Senior Clinical Psychologist, Medical Practitioner and Senior Child Protection Worker attend the three meetings along with the district care team (Case Manager, Team Leader, District Director, Assistant District Director, District Psychologist, Aboriginal Practice Leader) and any relevant external agencies. The medical team are called in to meetings where the child's medical health is of particular concern.

The initial planning meeting is designed to share important information and work collaboratively with the child's case worker, other relevant service providers, the child and their family, and to develop a plan that identifies the objectives to be worked towards while the child is in secure care and the needs of the child in his or her transition from secure care to other living arrangements. All exit and transition care planning, funding, services, referrals and actions should be documented and recorded as part of the secure care initial care planning meeting.

One District Director explained that the focus of the secure care initial planning meeting will be on the child's exit plan and that often the District will not have one. The District Director added that the Care Team responsible for the child are often exhausted physically and psychologically as a result of the crisis nature of the events leading up to the secure care admission. Hence the need for time to develop an exit plan contributes to the District seeking the maximum period of time for a child's stay. The District Director noted that KFSCC Management "are always understanding of our challenges and will do whatever they can within their capacity to genuinely support us". The theme outlined in this paragraph was also conveyed to the Evaluation at a focus group conducted with all District Directors.

[40] If a child has absconded from their residential facility, transport by Communities/Police is arranged once the child is located. For after-hours this is facilitated/coordinated via the State-wide Referral and Response Service.

Health team meetings occur each Monday. At these meetings each of the children are discussed, and medications / treatments and planning documents are reviewed. Every second Monday, the health team consults with a Child/Adolescent Psychiatrist by phone to assist with children's planning and care.

The view of District staff consulted was that KFSCC Management maintain very high standards with regard to meeting all the legislative requirements and their obligations and the timing of planning meetings and the discharging of children in accordance with their allocated secure care period.

Role of the Districts and KFSCC

Section 3.3.9 of the *Casework Practice Manual* details the procedures and practices for secure care arrangements. This document states that "a secure care arrangement must be viewed as a partnership between the district and secure care". It also outlines that the District responsible for the child in secure care "must commit to intensive collaborative work with the secure care team whilst the child is in residence and in planning for a return to the community". District staff described the level of intensive collaborative work undertaken with secure care staff as determined on a case by case basis with the three planned meetings generally a minimum. Examples of other collaborative work between District staff and KFSCC included the focus on a child's secure care goals, the development of a detailed trauma profile and the planning of the best options upon discharge. At a focus group discussion, District Directors described the approach between secure care and the districts as "shared problem solving" where all those involved worked hard at being "creative" in terms of planning for a child's exit and next placement.

District staff consulted for the Evaluation all identified that their role in the planning process is limited by the lack of safe placement/care arrangement options for children exiting secure care. As a result, the focus of the District becomes the child's placement options at the expense of any longer-term planning. District staff spoke of often only having a confirmed initial accommodation in place for a child and no other support services.

Planning documents

Section 88I of the CCSA requires a child's care plan (or provisional care plan) to be modified (or prepared) within two working days of a secure care arrangement being made. The care plan must:

- Identify the needs of the child in his or her transition to other living arrangements after leaving secure care.
- Outline steps or measures to address those needs and to reduce the likelihood of the child being readmitted to secure care.

It will also identify the agreed objectives, actions and tasks; who is responsible for them (note: the District is responsible for distributing the care plan to all necessary stakeholders, including explaining this to the child).

The care plan includes the child's objectives or intended goals of their secure care admission.[41] A review by the Evaluation of referral forms to secure care for the period January –April 2018 highlighted a range of goals specific to particular issues experienced by the young person as well as broader in scope. Some examples included:

[41] Report for Department of Communities. Assessor Visit – Kath French Secure Care Centre. Independent Follow-Up Assessment Report. March 2018, p.20

- supporting a young person with the aftermath of trauma related to their family of origin
- exploring how to begin to address a young person's experiences of trauma
- to enable some observation and assessment to be undertaken to determine how the young person can be best supported with their current behaviours
- providing a high level of acute therapeutic care and intervention
- providing education around sexual health and consent
- enabling a young person to gain some mastery over his behaviour in a positive way and to find that positive behaviours have positive impacts on his concept of self.

Duration of admission

Section 88F of the CCSA states that the secure care period must not exceed 21 days unless it is extended under subsection (3). While the secure care period cannot be extended more than once, there is no stated limit in the legislation as to the number of separate admissions a child can have to secure care.

Determining the duration of stay in secure care firstly involves the District recommending the number of days a child should be in secure care when they complete the Referral form. At the Secure Care initial planning meeting the District will consider, in partnership with the Secure Care team, if the full 21 days are required or if a shorter period at Secure Care will provide the stabilisation required and achieve the goals of admission. The Evaluation was informed by some District staff that determining the duration of stay is often a negotiated process and that many factors are considered, including the progress made while in secure care and the viability of returning to the previous placement. In particular, the fact that the District generally has no safe community alternative and therefore needs to seek the maximum period while all options are explored.

The *Policy on Children Entering Secure Care* states a child's secure care arrangement "should be as short as necessary". From 31 May 2011 to 30 April 2018 the average length of stay of a child in secure care was 18 days. The shortest stay of any child was one day, with a number of short stays being related to subsequent transfer to mental health or justice facilities. The average gap between admissions, for those admitted more than once, is 153 days, however;

- 36 readmissions were within ten days of discharge and of those, 14 were readmitted within two days of discharge
- 88 children had multiple admissions
- 18 children had over 100 total length of stay in days; the longest being [redacted] days over 20 admissions
- 36 children had re-entered secure care within 21 days of discharge after no extension.

By comparison, in Victoria's secure care facilities, the average length of stay is nine days. The Evaluation was informed that in Victoria there are a number of factors impacting on the duration of stay including capacity issues that mean there is a need to exit clients early so another client can come into the service. There is also an emphasis on ensuring secure care, especially for repeat cases, is approached as a very short 3-5 day stay to 'disrupt' immediate circumstances[42]. Other instances occur where a child or young person may be bailed to secure care overnight and the following day the department overseeing child protection will be notified and seek for them to exit immediately on the grounds that it is deemed not suitable. There can also be instances of children and young people exiting secure care prior to their exit date because other services have become available, for example

[42] The instances of short stay periods are likely to have an impact on statistical data reported against the SWS

a placement in a detoxification or mental health facility (an option not available in WA but which can be deployed through a multi-agency response).

Notwithstanding the differences in the Victorian secure care model to that of WA; if the incidents of "overnight" stays is removed from calculation of average days in Victoria, then the average length of stay would increase slightly to approximately 11 or 12 days per stay. This is still less than the average length of stay in secure care in WA of 18 days.

The Evaluation does not have outcome or risk reduction data for the Victorian secure care model. However, a cursory review of the frequency of readmission of distinct children into secure care for Victoria and WA does not indicate significant differences, despite the shorter duration of stay for the Victorian model.

Secure care extensions

Under section 88F of the CCSA, the CEO may extend the secure care period by not more than 21 days if he/she is satisfied that there are ***exceptional reasons*** for doing so. The 2015 KFSCC Assessor Report noted the lack of a definition under the CCSA section 88F (3) or in Communities policy regarding what constitutes an 'exceptional circumstance' to justify an extension to a child's stay. The 2015 Assessor report expressed a concern this lack of clarity or documentation on the criteria for extension could lead to its misuse by Districts seeking an extension. The Assessor suggested improving quality assurance processes for documents relating to decisions about secure care periods of stay and extensions (whilst the Evaluation did not specifically investigate possible misuse, it is acknowledged that there were no instances of misuse by Districts seeking an extension identified by the Evaluation).

The Evaluation noted that currently there is no formalised policy detailing the interpretation of the wording of the CCSA with criteria or rationale (threshold) to be applied when considering and making an application for extension. There is also an absence of documentation providing clarity with regard to the readmission of children after discharge and referrals for short period readmissions. A review of 52 [43]successful applications for extension indicated that 32 made direct reference to a continuing high level of risk, 26 indicated the lack of available appropriate accommodation, and 31 listed a lack of engagement in the program or a failure to progress towards goals as the basis for extensions.

Staff in some of the regional Districts consulted for this evaluation recognised that the challenges and costs involved in returning a child to secure care meant they would seek an extension if there was a belief that the child was not stable enough to return to the District and there was a very high risk of an immediate return to risk levels. For all secure care admissions from May 2011 to 30 April 2018, around a quarter were extended. When looking at the rate of extensions per annual admissions, there is a slight trend towards those from non-metropolitan regions and some differences across the country districts. Admissions from the South West District had nearly half of their admissions extended. This may be due to the South West having the highest number of high needs placements, that is, the most difficult children are living in this District and more likely to be referred to KFSCC.

2.2.2.3 Arrangements for transitioning from the KFSCC

The *Casework Practice Manual* states that all stakeholders are involved in planning for the transition of the child, however the relevant District retains responsibility for the development and implementation of the child's transition plan. Transition planning commences at admission and

[43] Note that there may be multiple reasons for extension

remains part of ongoing assessment, planning and review. KFSCC staff do not have a direct role in the decisions relating to the placement of a child after they exit secure care. The role of KFSCC is to provide information about the child's needs and behaviours to inform the District's decision about the best type of placement for the child. The *Policy on Children Entering Secure Care* states "secure care staff provide advice on appropriate strategies to relevant service providers and district staff, to enable them to more effectively manage the child's complex needs." It appears this is largely facilitated by the Discharge Summary prepared by the Senior Clinical Psychologist and, in some instances, communication between the Psychologist and service providers. All reports and case notes written by the Secure Care Officers and Education Officers are used to inform the discharge summary. The Discharge Summary provides sufficient background information and summary of admission to allow for a reasonable formulation of the child's predisposing, precipitating factors within a bio-psycho-social framework. Recommended future medical requirements, if known, are written into each child's Medical Discharge Summary. This will include comments in regard to the medical assessment/treatment and the specific counselling to address use of substances.

The literature on secure care and many stakeholders consulted for this evaluation highlight the importance of a child's transition from secure care, in particular, identifying a suitable placement and providing for ongoing support. Stability and the suitability of a child's placement after secure care is considered critical to reducing the potential for returns to extreme risk behaviours. Placement stability can result in positive outcomes for children and a stable, supportive environment can help children's re-engagement with education, while multiple care placements have the opposite effect.

Some of the barriers children and District staff experience with transitioning children from secure care are examined in more detail in Section 2.6.

2.2.2.4 Profile of the children being admitted to the KFSCC

The following figures summarise the number of children admitted to secure care identifying as Aboriginal, the gender of children admitted to secure care, admissions across the Districts, and age at admission (by gender) for the period May 2011 to April 2018.

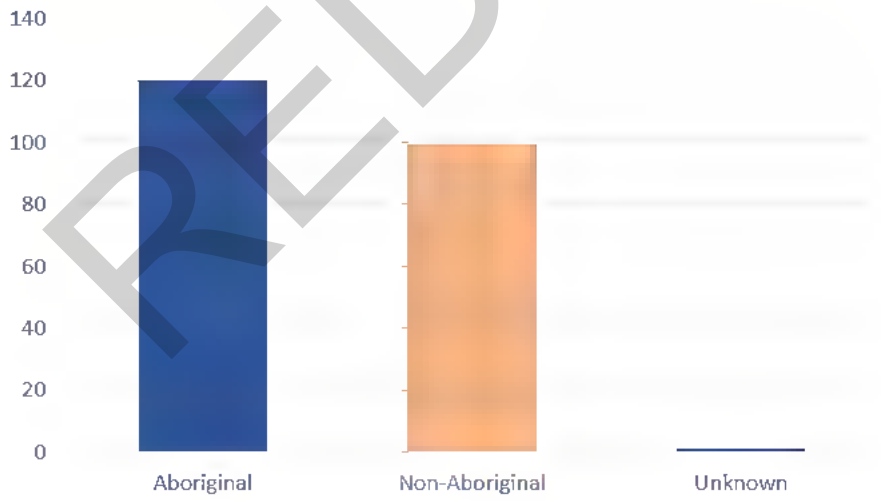

Figure 2-1: Distinct children admitted to secure care by Aboriginal and Torres Strait Islander Status (May 2011 to April 2018)

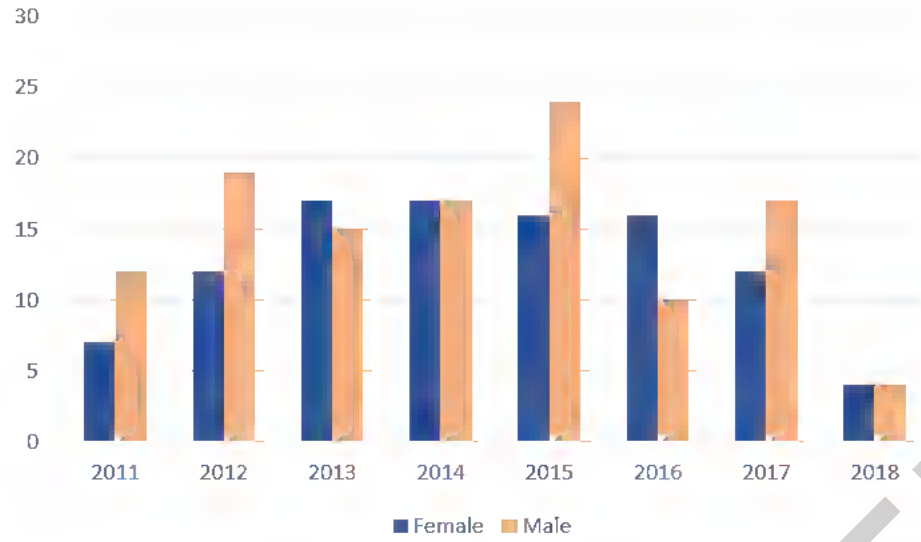

Figure 2-2: Gender of distinct children admitted to secure care by year (May 2011 to April 2018)

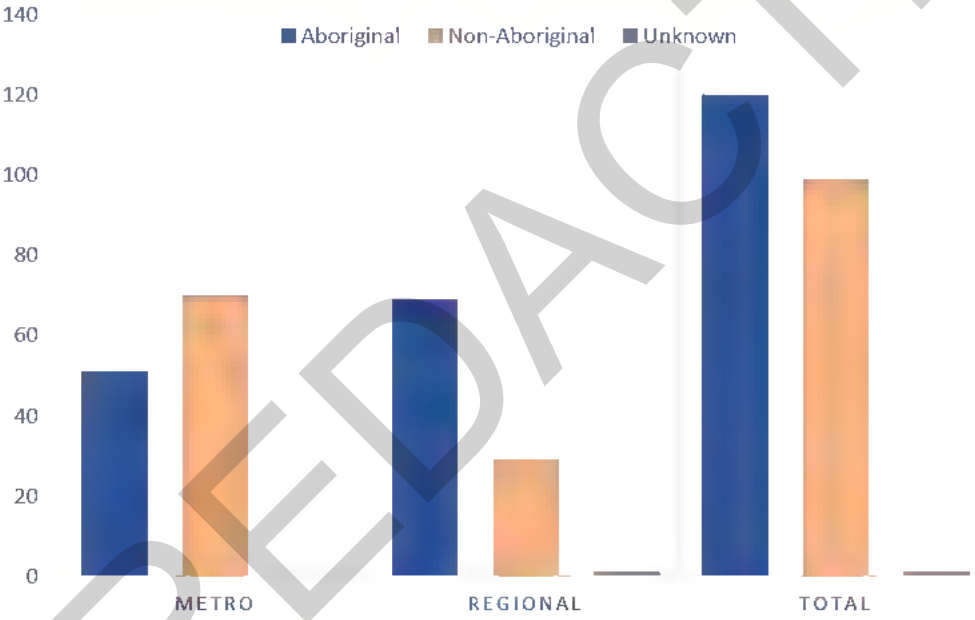

Figure 2-3: Number of distinct children to enter KFSCC – (May 2011 to April 2018) by region by Aboriginal status

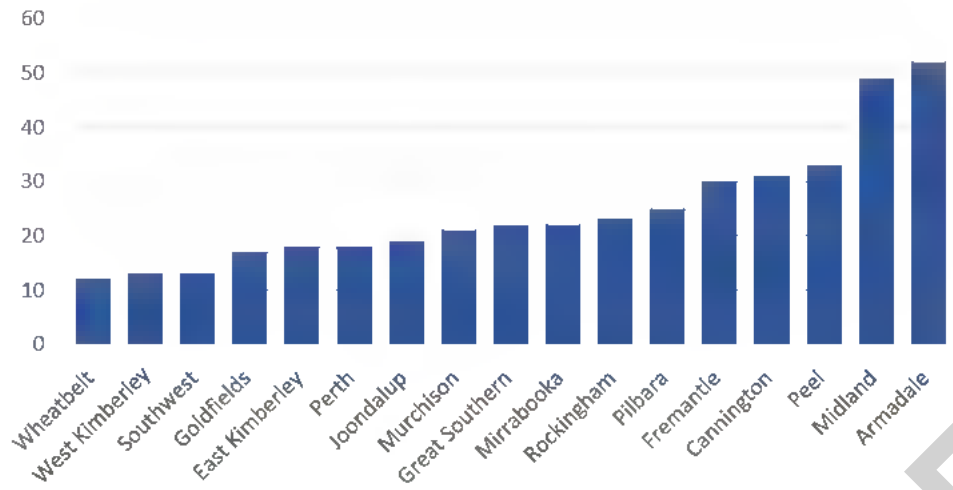

Figure 2-4: Number of admissions by district (May 2011 to April 2018)[44]

By way of context, Table 2-2 provides a summary of the number of children in care as at 30 June 2018. As might be expected, the number of children to enter secure care is reflective of the relative number of children in care by District.

Table 2-2: Children & young people in care by District – 30 June 2018

District	Aboriginal	Non-Aboriginal	Total
Armadale	288	242	530
Cannington	244	190	434
East Kimberley	157	0	157
Fremantle	161	141	302
Goldfields	117	25	142
Great Southern	100	67	167
Joondalup	114	214	328
Midland	231	210	441
Mirrabooka	182	185	367
Murchison	219	43	262
Peel	75	192	267
Perth	105	157	262
Pilbara	181	12	193
Rockingham	104	274	378
South West	131	199	330
West Kimberley	178	1	179
Wheatbelt	171	99	270
Fostering/Adoption	2	18	20
TOTAL	**2,760**	**2,269**	**5,029**

[44] Note, includes children who have more than one admission

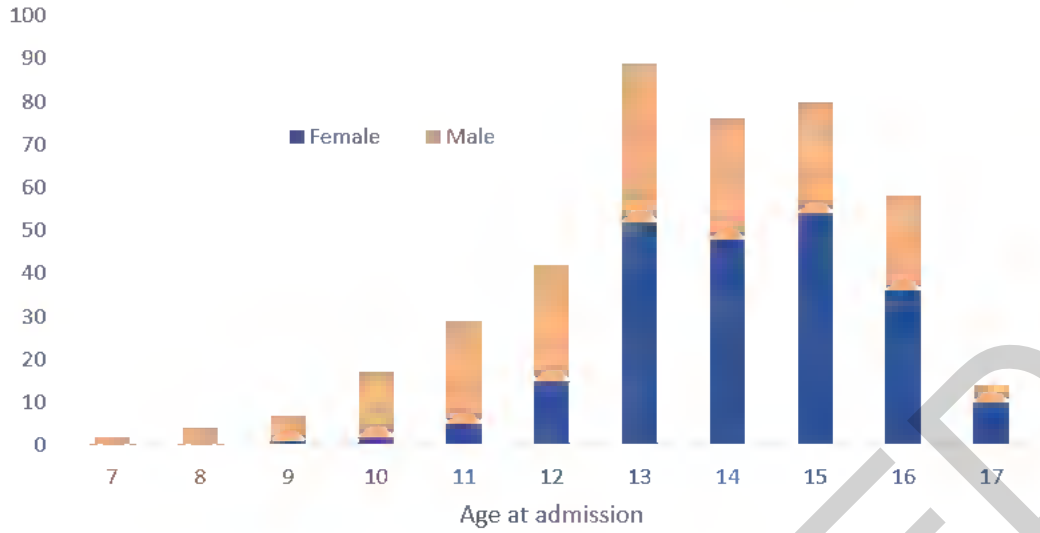

Figure 2-5: All children admitted to secure care by age at admission and gender (May 2011 to April 2018)

The average age of first admission was 13 years 2 months with median and most common, or mode, being 13 years of age. The ages for first admission ranged from seven years to 17 years, and as can be seen by the figure, a slightly skewed distribution to the older age with a standard deviation of approximately two years.

Children under 12 years of age

Secure care was not intended for children under 12 years of age although no minimum age limit for admission is specified within the legislation. The *Policy on Children Entering Secure Care* states only that it is "intended for children aged 12 to 17 years of age" and the *Casework Practice Manual* states "the recommended age group is 12-17 years of age". Of note is that the current policy[45] in Victoria specifies children aged "10 to 17 years" and requires senior executive review before referral of children under the age of 10 years. Children under 12 years of age first came to secure care in WA in 2013.

The Policy and Service Design (Children and Families) division within Communities recently undertook a thematic review of the under 12 years of age cohort who have been admitted to KFSCC since 2013. It notes the commonly documented reasons for referring children under the age of 12 to the KFSCC were to:

- Stabilise the child's behaviours while identifying a specialised placement and thereby minimising risk of future placement breakdown.
- Comprehensively assess the child and establish long-term supports.
- Enable comprehensive medical assessment and treatment, stabilise the child and conduct cognitive assessments.

[45] Child Protection Manual, Document ID number 2124, version 5, 2 July 2018., accessed from http://www.cpmanual.vic.gov.au

District staff consulted for the Evaluation suggested that the increasing use of the KFSCC for children under 12 years of age is in part due to the lack of options and supports, including mental health services, for these children.

The Statutory Review noted its concerns with the admission to secure care of children under 12 years of age and recommended that this should be avoided "where possible". It also recommended that alternative means for addressing the complex needs of this "small but increasing number of children" were "urgently required".[46] The issue of the appropriateness of the secure care service model for children under 12 years of age is examined in more detail in sections 2.3 and 2.7.

Children with possible mental health issues

Although secure care was not intended for children requiring a mental health facility, some stakeholders consulted for this Evaluation believe that there are children admitted to KFSCC with extreme, yet generally unassessed, mental health issues and needs. These children have generally not been able to access the mental health services they require prior to entering the centre, have not met the criteria for admission to an inpatient mental health facility, or have been discharged from an inpatient facility but remain at high levels of risk. District staff acknowledge that referral of these children to secure care is difficult because their behaviour, often a manifestation of their poor mental health, also coexists with other behaviours that meet the KFSCC admission criteria. This results in referrals for children with mental health issues who have been, in their view, prematurely discharged from a CAMHS facility, or deemed too unstable to be admitted to an inpatient facility, or have not been appropriately assessed. There is a view among District staff consulted that there are no other alternatives for children and young adolescents whose mental health issues pose an ongoing or chronic risk to themselves, and for those that pose a risk to others the mental health services are unwilling to admit them for treatment for either inpatient or out-patient management. [redacted][7]

In the Evaluation survey administered to KFSCC staff, some staff made reference to the centre being used for children who require more intensive therapeutic interventions. Comments included:

> *"There are a percentage of children who require support from alternative services (e.g. mental health), however systems have failed to meet that child's needs and hence they end up at Secure Care as a last resort. There have been a number of occasions where a child requires specialist intervention from health and/or mental health and no services or practitioners have been willing and/or able to support that child at secure care or in the community. It is difficult in that all parties involved know that secure care is not the best fit for this child, but nonetheless it is the only safe option given the lack of resourcing in other government departments."*

[46] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia, p.4

[47] Secure Care Referral Form

"For children who have more serious issues for example psychosis, severe depression/suicidal attempts the facility provides a space to keep them safe and alive however they would benefit from a larger team of external health professionals."

"We also sometimes have children who would benefit more from a comprehensive mental health service - which we are not. "

"I believe there are not enough child specific mental health services in WA which results in extra secure care admissions."

The secure care referral form asks, "Are there worries about the child's mental health?" Where this has been selected as 'yes' there is a requirement to indicate any past diagnoses and the doctor or mental health specialist making the diagnosis, all current treating doctors and any symptoms or signs of concern in relation to mental health. Of the 16 admissions to secure care from 1 January to 30 April 2018, only one form did not have "worries about mental health" as an identified factor in the referral with this marked as 'unknown', although details on the referral forms show diagnoses of significant post-traumatic stress disorder, anxiety, trauma, and borderline personality disorder.

Circumstances

While there were 21 children who were admitted to KFSCC on the same day that they were taken into care, most children had been under the care of Communities for a number of years prior to their first admission, with the average gap being approximately four and a half years. There are two major emerging themes in regard to the circumstances leading up to the admission of children to KFSCC.

i. For children who have chronic (i.e. long standing and ongoing) identified risks, there occurs a significant escalation in the risk behaviours (e.g., absconding for periods from the accommodations, aggression and property damage at school or in their residence, engaging in drug taking/substance use). The escalation is in terms of the:

   - intensity (e.g., minor property damage escalates to significant damage to a shop window and/or harm to residential staff or other residents)
   - duration (e.g., absconding goes from a few hours to days on the streets or whereabouts unknown for younger children)
   - frequency (e.g., the episodes of risk-taking behaviour or self-harm change from monthly/fortnightly to daily).

ii. Other children who have been admitted to another facility (e.g., Bentley Adolescent Unit /East Metropolitan Youth Unit or Princess Margaret (Children's) Hospital Ward 4H/Perth Children's Hospital Ward 5A; or Banksia Hill) and have been discharged from that service but continue to be considered at risk of harm to self (e.g., discharged from a mental health unit with suicidal ideation and intent) or others (e.g., charged and given bail to Communities, and have a recent history of offending against younger children that is not considered manageable in previous accommodation).

While these themes do not capture all the pathways to KFSCC, they represent the major themes. Minor themes are around the breakdown of the child's supports (e.g. the child leaves one residence to return to a house which is deemed unsuitable due to drug use/exploitation); and individual critical incidents (e.g., a child with a minimal history of risk behaviours returns to residence under the influence of substances multiple times in a short period). Risky behaviours and violence as a result of substance use/abuse is a common ground for a child's referral to secure care in combination with other risk behaviours such as absconding/offending/sexual exploitation.

2.2.3 Operations of the secure care model

The *Policy on Children Entering Secure Care* states: "Secure care provides planned, short-term intensive intervention in a therapeutic environment to contain, stabilise, assess and support the child's wellbeing." One submission to the Statutory Review suggests that KFSCC cannot undertake both assessments and intensive interventions in the time period children are at the centre. Rather, the submission suggests, KFSCC should be facilitating assessments where some of the child's needs and required therapeutic interventions can be identified and then planned for at the next placement.

Some interviews with stakeholders external to Communities highlighted a degree of confusion about the role of secure care in terms of the provision of assessments and interventions. Some interviewees assumed children in secure care access a range of 'therapeutic interventions'. This should be addressed by Communities continuing to clearly articulate to external stakeholders the secure care model. District staff consulted for the Evaluation understood the 'short term intensive interventions' to be the learning activities and 'therapeutic conversations' children and staff engage in, particularly around safety, protective behaviours and managing stress and anger. Most District staff consulted for the Evaluation regard these activities as beneficial for most children and an important aspect of their secure care arrangement.

2.2.3.1 Assessment of children

Consultations with District staff highlighted views about the role of assessments in secure care and a perception that the purpose of secure care had shifted from its initial intent of 'contain and assess' because of the lack of assessments taking place. Several commented that the current assessment process at KFSCC was a gap. It was suggested that, ideally, KFSCC would be in a position to facilitate more assessments for children, including those that can be conducted by KFSCC staff as well as bringing in other services as required. One District staff member specifically commented that it can be difficult to arrange and get children to assessments when they are in the community because of their level of disengagement. They suggest secure care offered a good opportunity to undertake a range of assessments for children, such as an educational assessment /Weschler Intelligence Scale for Children and cognitive assessments. A District Team Leader noted that without knowing whether a child's behaviour is attachment- and trauma-related, substance use related or a serious and ongoing mental health issue, it was very difficult for a caseworker's future planning for the child. Another District Director commented that there was not a lot of point in undertaking assessments for children in secure care because of the challenges in accessing any services to meet the needs identified.

The Evaluation was informed by KFSCC Management that implementation of clinical, evidence-based assessments to establish current and long-term needs and risks to help prevent repeat patterns of high-risk behaviours is not part of standard practice within the KFSCC. Standardised cognitive psychometric assessments are only undertaken on request and as required. The Evaluation did not observe evidence of any formal assessments of children in secure care. For example, it was noted that a mental state exam - a basic formal assessment of current functioning - is not conducted on admission or prior to discharge.

The Senior Clinical Psychologist compiles a series of therapeutic planning documents – 'the pack' for each child. This contains extracted information from a child's online file, held by Communities. The pack is usually compiled before a child's physical admission to the centre and contains a Safety Plan, Trauma Profile, Medical Issues Form, Brief History and Therapeutic Response Plan. All staff at the centre have access to this information. It is also available on *Objective* for other Departmental staff. The team observed that the therapeutic packs compiled for each admission were largely based on case files and information accessed about the child prior to their secure care admission and before

the Senior Clinical Psychologist had met or spoken with the child. However, these are reviewed and amended daily or when indicated, by KFSCC staff. There is a concern that given the challenges expressed by some District staff with regard to a lack of assessments for many children who are referred to secure care, that this material may not provide a complete view of the child's immediate needs and issues. The Evaluation was informed that the role of the KFSCC Senior Clinical Psychologist is not to provide direct assessment or treatment to the children, but rather to support therapeutic trauma informed practice by the Secure Care Officers who build and maintain what are considered the most influential relationships with the children. The Senior Clinical Psychologist also produces a Discharge Summary at the child's point of exit.

District staff talked about the difficulties of accessing the services of relevant professionals, especially private psychiatrists who are prepared to go to KFSCC. The Evaluation was informed that there are numerous attempts made by the Districts to have interventions/assessments occur while a child is in secure care. Some suggested secure care requires an arrangement that provides for better access to a child/adolescent psychiatrist who can attend the facility.

The 2017 Assessor Report noted that KFSCC Management expressed the view that a District's expectation of a full psychiatric assessment being conducted while a child was at the centre was "unrealistic" due to the 21 day time frame and difficulties sourcing a child psychiatrist who will come to the centre. The Evaluation was informed that current arrangements are that every second Monday the KFSCC health team consults by phone with a Child/Adolescent Psychiatrist to assist with children's planning and care.

The Evaluation was informed that of the 16 admissions[48] between January 2018 and April 2018 and, as an indication of mental health involvement with admissions, the following occurred in secure care:

- [redacted] fitness to plead assessment, [redacted] psychiatric review [redacted] undertaken by a psychiatrist brought to KFSCC).
- [redacted] ongoing therapy sessions provided by a psychologist (external practitioner).
- [redacted] commenced therapy and had an initial session at KFSCC with a psychologist (external practitioner).
- [redacted] interaction with a District psychologist via video conferencing to continue therapeutic work.

Of those mentioned above, [redacted] had contact with both a psychiatrist and a psychologist during admission. Some of the children had pre-referrals to psychology but were waitlisted. Some children also had a psychologist or engagement with CAMHS prior to secure care but did not have visits during their admissions. A number of Districts wanted a psychiatric review, but this was not able to be organised within the timeframe. Further information in relation to engagement with psychology/psychiatry is included in a child's discharge summary under "Mental Health, Counselling and Therapeutic Relationships".

Of note is the approach adopted by SWS in Victoria, which outsources psychology services from Berry Street's (incorporated association) *Take Two* Program, a partnership between:

- La Trobe University: Social Work and Social Policy, Department of Community and Allied Health
- Mindful Centre for Training and Research in Developmental Health

[48] Note, one child was admitted twice during this period.

- Victorian Aboriginal Child Care Agency.

Take Two are contracted to provide consultations to 100 youth per annum at SWS (approx. 3 to 4 per week). The objective of the psychology service is to:

- carry out assessments or secondary consults on young people, as per referrals completed by child protection practitioners
- produce an outline of the current presentation of the young person
- make recommendations on required follow up by the child protection practitioner.

2.2.3.2 *Responsiveness of the model to meet the specific needs of Aboriginal children and children with disabilities*

Aboriginal children

From 31 May 2011 to 30 April 2018 there had been 120 children (54%) who identified as Aboriginal and/or Torres Strait Islander admitted to secure care. Of the 40 children aged under 12 years of age at the time of admission, 29 (73%) identified as either Aboriginal or Torres Strait Islander, which is significantly above the total KFSCC cohort (55% identified). As can be seen from the figure below, the proportion of children admitted to secure care over the period examined is far greater than the representation of Aboriginal and Torres Strait Islander in the total population and for school aged children in WA (noting that the age distribution for indigenous and non-indigenous populations have significant differences). However, the proportion of admissions to secure care is consistent with the ratio of children in OoHC in WA in 2017.[49]

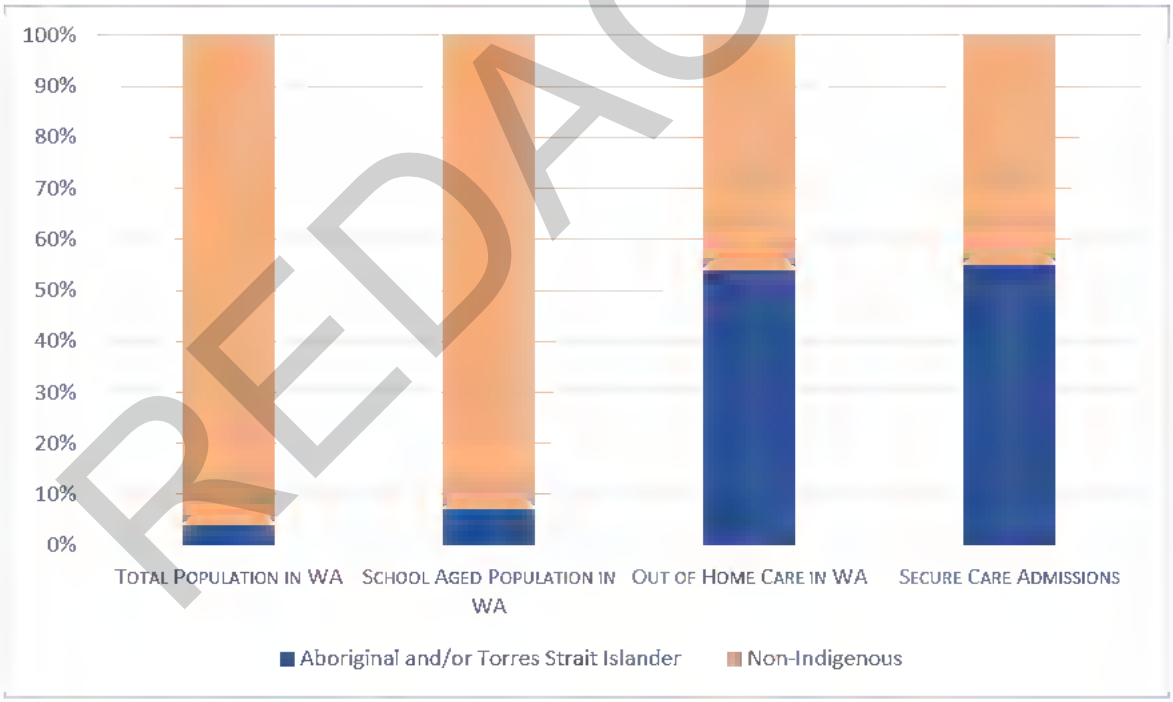

Figure 2-6: Comparison of proportion of admissions identified as ATSI (May 2011 to April 2018)

For many Aboriginal children, a secure care arrangement involves removal from their country. Regional District staff consulted described the challenges and dilemmas they face with removing

[49] From the Department of Communities Annual Report, 2016-17, available from dcp.wa.gov.au

Aboriginal children from country, community and extended family. Such children's complex needs and safety cannot be met in their communities and current living arrangements. Yet removal to secure care followed by a placement in Perth or a larger regional town can be detrimental and trigger a range of risk behaviour such as absconding, substance/solvent misuse, and rejection of support services. For other Aboriginal children, some District staff felt that being on country is a contributing factor to their trauma and risk and that removing them is, in many ways, in their best interests. Regional District staff spoke of some children who themselves acknowledged the negative influence of being on country but were still very sad that they had to be apart from their family and/or community.

As part of the development of a new set of Standards of OoHC in WA the CREATE Foundation was engaged to consult with children and young people about their statutory care experiences. CREATE asked Aboriginal young people in OoHC to identify what makes them feel connected to family, community and culture. Those who participated in the consultations spoke about the following:

- Contact with family, both immediate and extended.
- Knowledge and cultural education.
- Being informed about country and being able to go to country.
- Having support from the adults in their lives.[50]

Meeting the needs of Aboriginal children in KFSCC is challenging. The reality is that contact with family and access to the cultural activities an Aboriginal child may usually access cannot be accommodated in secure care nor in many placements if they are a long way from their community. The use of tailored activities designed to respond to the needs of each child whilst in secure care extends to attempting to meet the specific needs of Aboriginal children. KFSCC Management informed the Evaluation that specific provisions utilised by the centre for their response to Aboriginal children make use of:

- Story Animals – used for combining trauma information and cultural safety.
- Aboriginal art to include culture and creativity.
- Tindale map – incorporating language groups and information on different areas of Australia.
- Language posters and books – specific to different areas of the country – as part of the daily program.
- Music, TV shows and movies – both documentary and entertainment.
- Aboriginal interpreting service.
- Aboriginal healers onsite.
- Smoking ceremonies are held regularly.
- Obtaining soils from local areas in consultation with Elders and as appropriate for use while the child is in secure care.
- Photos and symbols to help children feel connected to culture and country while in secure care.
- Ongoing training for staff to maintain cultural competence.
- Ongoing relationship with local Elders, celebration of special events – such as NAIDOC, Sorry Day, Reconciliation Week.
- Engagement with Nyoongar Wellbeing and Sports on a monthly basis.

District staff with children in remote regions spoke of the efforts KFSCC Management and staff make to accommodate children from remote areas. They made reference to KFSCC requesting photos of a child's country, a parcel of sand or dirt, and linking children with phone calls and videoconference

[50] CREATE Foundation. Standards of Out of Home Care – The Voices of Children and Young People. WA. 2017

where possible and if requested. District staff reported that KFSCC Management were particularly aware of the issues and challenges for Aboriginal children and the importance of recognising their culture and the significance of country to their wellbeing. The Evaluation also observed:

- KFSCC Management demonstrated a good understanding of the importance of cultural connection for Aboriginal children.
- Evidence of education staff engaging in activities with Aboriginal children that had 'cultural' content.
- A great deal of effort was made to work with Aboriginal children in a respectful and culturally appropriate way as possible within the limits of a locked facility.

District staff talked about the difficulties of returning many Aboriginal children to their community and the need to place them in residential care homes or, if possible, high needs transitional housing which are not provided in many northern regional centres. One District Director talked of the challenges the extended family can experience in trying to cope with children with extremely complex needs and often grandparents who have nominated to care for the child are unable to meet the child's needs, sustain a level of support after secure care or prevent the child from returning to risk. There is often no other suitable family or option available to ensure children are placed with Aboriginal family or carers.

With regard to the Aboriginal and Torres Strait Islander Child Placement Principle in section 12 of the CCSA, and the extent to which it can apply in secure care, the KFSCC Management acknowledged that it is always considered in discussions when working with Aboriginal children. However, they also note that secure care does not have a direct role in decisions relating to the placement of a child following secure care and that how the principle is applied in those decisions is the responsibility of the Districts.

2.2.3.3 Cultural Plans

All Aboriginal children in OoHC are required to have a personal and up to date Culture and Identity Plan. These plans are to be specific to meet the child or young person's needs, developed upon their entry into care, reviewed at least annually, and when transitions occur.

It is considered that there is merit that the Culture and Identity Plan form part of the KFSCC referral and occur following consultation with a relevant Aboriginal Practice Leader to identify and inform the admission process around any particular culturally relevant issues that might impact the admission of the young person.

KFSCC Management state that "a child's cultural needs are always part of discussion for children at Secure Care"[51]. The following particulars were also provided in response to a query regarding actions undertaken at KFSCC to promote adherence to requirements of the Aboriginal and Torres Strait Islander Child Placement Principle.

- Communication of a child's cultural background is on all documentation and noted in all meetings as an area of focus.
- Cultural safety is a specific area of safety on a child's safety plan.
- Considerations are made for contact in remote locations and in complex family situations.

[51] Email correspondence with KFSCC Management

- Use of culturally specific psychometrics (Westerman Aboriginal Symptom Checklist[52]) and understanding of Aboriginal mental health.

With regard to additional comments about secure care in the KFSCC staff surveys, one staff member suggested it would be beneficial for "all Secure Care Officers to participate and attain qualification in Cultural Leadership. The Centre needs to have an Aboriginal Practice Leader. More Aboriginal Secure Care Officers." In relation to this discussion, the Evaluation notes that an Aboriginal Practice Leader visits the KFSCC approximately one day per month.

2.2.3.4 Children with disabilities

One study in WA, using linked administrative data, found that children with disabilities were present in almost 1 in 3 substantiated maltreatment allegations between 1990 and 2010, with increased maltreatment risk among those children with intellectual disability, mental/behavioural problems and conduct disorder. The proportion of Aboriginal children with disability is also higher compared with non-Aboriginal children. The prevalence of disabilities in the child protection system suggests a need for awareness of the scope of issues faced by these children and the need for interagency collaboration to ensure children's complex needs are met.[53] There is also the need to consider that many children's intellectual disabilities are not properly diagnosed or assessed, for instance Foetal Alcohol Spectrum Disorder. Given the elevated risk amongst the children in care cohort, it would be expected that admission to secure care would reflect this risk understanding and require the appropriate adjustments and accommodations.

From the data provided to the Evaluation on admissions from May 2011 to the end of April 2018, the Evaluation identified that while there is no statistically significant differences between those admitted to secure care with recognised disabilities and those without, those with disabilities were more likely to have more admissions, to be slightly older and to have longer stays, and be more likely to also have been incarcerated in Banksia Hill Detention Centre. They also experienced slightly more critical incidents while in KFSCC but this may be accounted for by their longer and more frequent stays.

Table 2-3: Admissions to secure care- presence of disability (May 2011 – April 2018)

	Average Number of admissions	Age at first admission	Number of Critical Incidents**	Total length of stay in days	Average length of stay	Placements at Banksia Hill
With Disability* (n=45, 20.5%)	2.07	14.12	6.17	49.77	23.15	4.15
Without Disability (n=174, 79.5%)	1.85	13.79	5.39	37.73	20.88	2.67
Total	1.90	13.87	5.58	40.62	21.42	3.15

*With a disability and/or registration with Disability Services Commission recorded in the Assist child protection client system

**While in Secure Care

In terms of how secure care provides for and responds to children with a disability including an intellectual disability, KFSCC Management state that they address all children's needs on an individual

[52] Refer to Indigenous Psychological Services, online at https://indigenouspsychservices.com.au/products-tests/wascy/

[53] Maclean M, Sims S, Leonard H, Bower C, Stanley F, O'Donnell M. (2017). Maltreatment risk among children with disabilities. *Paediatrics*, 139 (4).

basis. Children's capacity is considered and reflected in planning documentation. This could include visual supports, safety planning, staffing, communication guidelines, daily activities, medical supports, and diet. Where possible KFSCC also engage disability services to consult and assist with planning.

However, some KFSCC staff commented in the surveys that they did not feel they had the skills or training to work effectively with children with disabilities, with one commenting;

> *"We are challenged by children with disabilities as we do not receive disability specific training."*

From a limited sample of file reviews (14.6% of all case files) undertaken by the Evaluation, the common disabilities identified were cognitive (i.e. intellectual disability, learning disabilities/difficulties [e.g., attention deficit hyperactivity disorder, dyslexia], and Autism Spectrum Disorders) rather than physical. In this regard, whilst the general framework applied to identifying training needs of KFSCC staff is considered appropriate, it is suggested however, that KFSCC Management periodically review the staff skills/training requirements in working with children with disabilities.

2.2.4 Summary

The Evaluation notes that secure care is largely operating as intended. The secure care facility was never intended to be a placement option. It was to be utilised as an option of last resort and for the shortest time possible to remove the child from immediate risk and establish a measure of stabilisation. It was not intended for children under 12 years of age. However, in the seven years since secure care was established and the original intent described, the landscape of children in care and their needs is, according to those working in the sector, becoming increasingly challenging and more complex. This is reflected in the younger age of children requiring secure care, the prevalence of mental health needs of many children, the need for many children to be in secure care for as long as possible, and the lack of services and facilities for children in care and exiting secure care with extremely complex needs.

While the original intent of the CCSA may have envisioned for children to remain in secure care for the shortest period necessary to stabilise the child, there appears to have been a shift to a view of 21 days as a "standard" among District staff. This is likely to reflect a combination of:

- limited accommodation options available that provide high level care/intensive supervision pertinent to a child exiting secure care
- a discretionary overlay by KFSCC Management that the interests of the child are best served by working with the child over the maximum duration of 21 days (rather than a shorter duration)
- limited flexibility in the CCSA to facilitate modified programs and transition to the community.

Furthermore, when considering the intent of the CCSA, the Evaluation found limited compelling evidence that the current maximum timeframes in which a child may be placed in secure care should be extended. Conversely, a number of factors support a view that the current operating model/approach may be resulting in children remaining in secure care longer than the intent of the legislation. These factors include:

- A number of the admissions into KFSCC comprises children engaged in substance use and which can generally be stabilised within a 7 to 10 day timeframe.
- Examples exist of operating models similar to that of the KFSCC where the duration of admission into secure care is less than the current duration occurring in WA – e.g.

Victoria where release of a child from secure care is able to occur within a shorter time period (9 to 12 days) than the current 18 day average for KFSCC[54].

2.2.5 Recommendations

On the basis that good assessment greatly increases the likelihood of identifying appropriate supports post-secure care and in measuring and improving social, health and educational outcomes, the Evaluation recommends:

Recommendation 1 - (If not already undertaken) That a comprehensive assessment of children admitted in to KFSCC be undertaken comprising:

- screening for particular conditions (e.g., intellectual disability, depression, anxiety) and a comprehensive bio (medical)-psycho (Mental State Examination and screening for mood disorders) and social (peer/staff interactions) assessment, and
- educational functioning/needs assessment.

Recommendation 2 - That the current *Policy on Children Entering Secure Care* be further developed to provide greater clarity and guidance in interpreting the wording of the CCSA with regard to section 88C "*there is an immediate and substantial risk of the child causing significant harm to the child or another person*" for referral and "*exceptional reasons*" for extensions with accompanying standard (controlled) forms and practice notes.

That a policy be developed regarding when KFSCC is near or at capacity to provide transparency in regard to the determination of referral consideration.

Recommendation 3 - Address the specific cultural needs of Aboriginal children entering secure care by:

- Assessing the Aboriginal cultural competency of all KFSCC staff through the application of the Aboriginal Mental Health Cultural Competency Profile and provide appropriate responses.
- Ensuring the Culture and Identity Plan is included in the KFSCC referral supported by consultation with a relevant Aboriginal Practice Leader to identify and inform the admission process around any particular culturally relevant issues that might impact the admission of the young person.

[54] The Victorian secure care model has a number of similarities to that of WA. (E.g. WA legislation was primarily based upon the Victorian legislation and which is reflected in similarities including: the admission criteria; the maximum duration of admission (21 days); the framework for extension of admission and comparable size of facilities when taking into account population size

2.3 Is the admission criteria and service model appropriate for responding to young people in care with extremely complex needs?

2.3.1 Method

The following methods were utilised to consider the appropriateness of the admission criteria to secure care and the service model in identifying and responding to children in care with extremely complex needs.

- Document review: including *Children and Community Services Act 2004*, Second Reading Speech, *Policy on Children Entering Secure Care*, KFSCC Tip Sheet for Crisis Care, *Statutory Review of the Children and Community Services Act 2004*, *Review of the Kath French Secure Care Centre – Under 12 year old Cohort* (May 2018), *Casework Practice Manual*.
- Consultations with stakeholders including District staff.
- Correspondence with KFSCC Management.
- KFSCC staff surveys.
- Feedback forms completed by children on exit from KFSCC.
- Desktop review of relevant literature and published research.
- Case file reviews.

2.3.2 Findings

2.3.2.1 Admission criteria

In order for a child to be admitted to secure care, the CEO of the Department must be satisfied that the following criteria, from section 88C of the CCSA, are met:

(a) there is an immediate and substantial risk of the child causing significant harm to him or herself or another person; and

(b) there is no other suitable way to manage that risk and to support the child to receive the care he or she needs.

Various documents reinforce the criteria for admission to secure care stated in the legislation and provide further details around what is not regarded as a basis for referral to secure care. The KFSCC Tip Sheet for Crisis Care states "it is not the intention of the legislation for the centre to be used as an emergency accommodation option". The *Policy on Children Entering Secure Care* states "Placing a child in secure care should be an intervention of last resort after all other options to manage the risks the child presents to him/herself or another person have been fully utilised." It also details circumstances where it is not appropriate to place a child in secure care:

- As a placement option in the absence of any alternative placement arrangement.
- The child exhibits behaviours, signs or symptoms indicating possible mental illness, suicide risk or significant self-harm without the provision of a full discharge summary or letter, by a mental health professional outlining the level of risk to the child and confirming that the child does not require hospital admission. Where a mental illness is suspected, requiring medication and/or a possible inpatient admission, a referral to specialist service(s) is the first priority.

- As an alternative option for children remanded in custody or serving a period of detention. Secure care is not punitive detention and the criminal justice jurisdiction does not have the power to make a secure care arrangement for a child.
- Children with high medical needs who require 24 hour monitoring/supervision or those with severe disability, as secure care does not have the capacity to meet their needs.

A review of a sample of 17 admissions found that they all met the criteria in the CCSA for admission to a secure care facility. Consultations with stakeholders also suggest the admission criteria for secure care identifies a small number of children who are at extreme risk. There was a consensus among District staff consulted for the Evaluation that children referred to secure care are "out of control", all means of seeking to mitigate their behaviour and keep them safe have failed, they need to be removed from their circumstances and there is "literally nowhere else" where their safety can be assured. That said, the admission criteria are also described by some stakeholders as challenging to interpret when seeking a referral. One District Director remarked that the criteria were too broad and open to interpretation. Other District Directors commented that at different times the criteria could both assist and hamper their efforts to assist children at extreme risk. Another District staff member suggested that the criteria could be confusing because they might have a child who they had identified as meeting the criteria and yet are informed this was not the case but acknowledged how 'extreme' the level of risk was for a child could be dependent on the individual child and their individual circumstances. KFSCC Management noted that tip sheets were developed to assist with completing referrals, and the criteria has been consistent since KFSCC opened.

District staff noted how they apply the criteria to determine if a child should be referred to secure care can vary. For instance, what they considered extreme risk is different for an 8 year old to that of a 15 year old. The *Policy on Children Entering Secure Care* states that it is not appropriate to use secure care "as a placement option in the ***absence of any alternative placement arrangement".*** However, consultations with District staff highlight that this is exactly the situation they face with some children at extreme levels of risk, especially those with mental health issues. Furthermore, they often continue to face an absence of any alternative placement arrangements when planning for a child's transition from secure care.

Consultations with representatives from CAMHS and Department of Justice highlight some apparent confusion about the role of secure care and, in particular, the admission criteria. One stakeholder commented "I don't get the criteria, it changes all the time". Another claimed it was "unclear" why some children get accepted and others do not. It was also suggested that Communities staff will use CAMHS hospital services to avoid the KFSCC referral process because the admission criteria are so restrictive. However, if stakeholders are accessing hospital services, this would deem the child unsuitable for secure care due to the prime issue being that of mental health requiring inpatient care. It was suggested that children may be referred to KFSCC following refusal of mental health services to provide inpatient care; with the child remaining at significant risk. Whereas those working in juvenile justice suggested referring children from Banksia to KFSCC was easier than attempting to have them admitted to Bentley Adolescent Unit (now known as the East Metropolitan Youth Unit).

2.3.2.2 Risk assessment

The referrals for admission address the criteria of risk, generally summarising historical or "static" factors that predispose the child to the behaviours of concern (e.g. history of trauma and lack of stable attachments). The referrals tend to largely include information already on file regarding the child's history and incidents and limited information of the predisposing or "dynamic" factors that have escalated the behaviours and related risks – and how admission to KFSCC will assist in addressing those factors. The use of an appropriate standardised risk assessment instrument (like the Short-Term

Assessment of Risk and Treatability: Adolescent Version - START-AV[55], notwithstanding its limited validity outside of the United Kingdom and limited independent research specifically with indigenous adolescent populations) would provide more clarity as to the static/dynamic factors (for example some children have histories of self-harm that are relatively stable then they have a situational crisis with a break up or loss of significant other and their self-harming escalates in severity/frequency - their use of self-harm is linked to their history of abuse/neglect but the escalation is due to the current context).

2.3.2.3 Duration of stay for children with extremely complex needs

Consultations with District staff and survey responses from KFSCC staff suggest many regard 21 days or less as limiting the capacity of the secure care model to respond to the child's high risk behaviour patterns in a sustainable way. It also makes it difficult for those responsible for the child to regroup, reassess and develop a viable future care plan and secure a placement. Many of those consulted describe a typical cycle many children go through whilst in secure care. This involves a period of initial, often negative, reaction to the situation which can subside quickly depending on each individual. This is then followed by a settling of the child who is considered by staff to be adapting to the environment, often occurring during the second week. This is considered the time when there can be some positive interactions between the child and staff. However, as many staff acknowledge, this stability is often challenged during the third week/later stages of a child's secure care period, by the fact that the child is having to prepare to leave the centre, which often causes anxiety, uncertainty, stress and tends to absorb the child's focus.

One KFSCC staff member made the following observation about the service model:

> *"The stay at the Kath French Centre is very brief for children and even though it is intensive, only so much can happen in terms of change. Increasing the length of stay may help children become more equipped and foster more personal growth."*

Another KFSCC staff member commented:

> *"some children would benefit from an increased length of stay to ensure that they are ready for transition to the community - if there is a longer period of admission, then there may be more opportunity for therapeutic activities and engagement that can address deeper levels of trauma (or trauma processing). This would also allow more time for integrated therapies to be incorporated in to the program."*

A District Clinical Psychologist made the following observation:

> *"I believe Secure Care is effective but too focused on being time limited...I think it is often perhaps not long enough...and the length of time should have some level of discretion built in."*

Some of those consulted admitted that the needs of some children are such that they require a great deal of intensive work that the system currently cannot accommodate. They noted that for these children, long term stabilisation is required and is never going to be achieved in 21 or even 42 days. Rather, the experience for many of these children is a "ping-ponging" from high needs placements, secure care, hospital, sometimes back to secure care and in some cases, juvenile detention.

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[55] Refer Centre for Youth and Criminal Justice (2018). *Balancing rights and risk: How can we get it right for children involved in violent behaviour?*, retrieved from https://www.cycj.org.uk/wp-content/uploads/2018/10/Balancing-Rights-and-Risk.pdf

2.3.2.4 *Therapeutic model of care*

The *Policy on Children Entering Secure Care* describes secure care as "a time-limited 'circuit breaker' to stabilise the child's behaviours". Stabilisation is said to be achieved through a therapeutic model of care that is individually tailored to the child's needs, is culturally responsive and takes into account their views. It is said to involve non-punitive, individualised responses to behaviour and regularity strategies, with the use of a safe room for dealing with critical incidents. The goals of the service model are described in the policy document as "to work with the child to prevent repeating a pattern of high risk behaviours, develop life skills, establish a network of proactive supports with the child's family and other agencies, and transition the child's return to the community."

The Evaluation was informed that due to a child's limited time at secure care, priority is placed on obtaining safety for the child to provide stability and a return to baseline. The aim is to enable therapeutic, educative and other interventions to be put in place for the child after they leave secure care. The KFSCC Education officers write a daily report on any activities/learning undertaken with each child. The Education Officer summary reports are read aloud at each meeting and recorded in the weekly minutes. These reports are saved on *Objective* and the Districts have immediate access to these records.

Within the first two days of their stay children are supported to create their own unique self-care strategies. Self-care strategies are raised with the children as a reminder each time an escalation in their behaviour is observed. Self-care plans include both activities that a child can do alone as well as those that involve others.

The feedback forms children complete on exiting secure care asks if they made a self-care plan while at secure care. Of the 168 completed forms, 110 children (65.5%) wrote 'yes'. Figure 2-7 details those 110 responses with regard to how helpful the children found the self-care plan – as positive, negative or a neutral view.

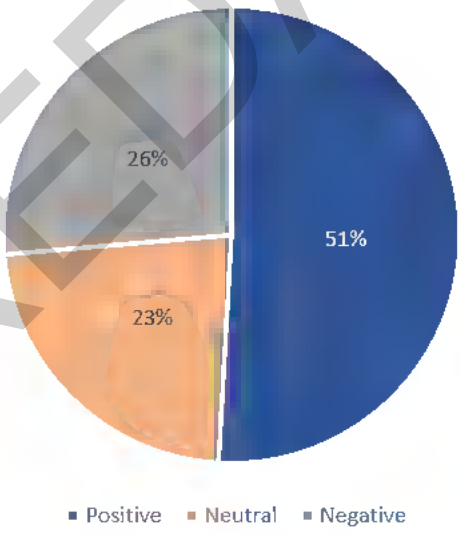

Figure 2-7: Proportion of children rating the helpfulness of self-care plans

Some of the children's comments with regard to how the self-care plan was helpful:

> *"it helps me to regulate"*
>
> *"helps me when I'm angry"*

"it helped me set goals for myself"

"helpful to show me things I could do when I am angry or upset"

"it helped me calm myself down"

Secure Care Officers and KFSCC Education Officers seek to engage children in some learning and psycho-education activities, engaging in conversations about safe relationships, protective behaviours, drug and alcohol education and awareness, and greater understanding about triggers for anger, anxiety and stress. In their surveys KFSCC staff described the range of activities they engage in with the children including Cake Splat, Water play - slides, water balloons, Bang Bang Balloon, making playdough, cooking activities, card games, arts and crafts, board games, outdoor sports - basketball, soccer, football, trampoline; interactive play - treasure hunts, cubby making, watching documentaries and movies, X-box or Wii, self-care strategies particularly with teenage girls such as face masks, foot soaks, hair braiding, etc.

The KFSCC Education Officers and SCOs are responsible for provision of selected learning activities and psycho-education to meet the individual needs of each child. Activities are targeted at building the skills and knowledge required for each child, with a focus on developing coping skills. Activities are designed to engage the child in areas of interest.

Community meetings are held daily at the KFSCC as a tool to bring staff and children together and are described as an opportunity to take the "pulse" of the group before beginning the day or beginning a meeting. Self-care plans are used within the Centre as a visual reminder for both staff and children about the need for each individual to manage emotions in order to keep themselves and others safe. Staff are required to wear their Self-care cards at all times.

KFSCC staff comments in the surveys provide differing views of their role. Comments include[56]:

"Provide a safe, secure caring environment."

"To support children environmentally and emotionally to reduce stress and risk. Also to teach them better ways to cope with stress."

"Our main role here is to keep the children that come here safe. Although we are able to keep the children safe more often than not it feels like we are glorified baby sitters."

The *Policy on Children Entering Secure Care* states "children residing in secure care receive a range of services onsite including education". The Evaluation observed, and consultations with KFSCC and Communities staff confirmed, that many children in secure care have been disengaged from education for some time. This has impacted a range of skill levels including their literacy and numeracy. KFSCC staff recognise these challenges and provide children with what they refer to as "learning activities" that are flexible in terms of delivery, and depend on whether a child can safely be engaged to participate, rather being pre-planned and scheduled for particular days and times that may not be appropriate for the child's state at the time. KFSCC staff and management acknowledge that the activities are not intended to re-engage or continue a child's education. The provision of onsite education in consultation with a child's school and District Education Officer, is not part of standard practice within the Centre. Reading assessments are undertaken with some children. There are no consistently used spelling, comprehension or numeracy assessments conducted at KFSCC to establish educational strengths and areas for development. Communities Education Officers consulted also subscribed to the view that secure care is not an appropriate environment to conduct education

[56] The Evaluation acknowledges that the comments selected may not be representative of the majority of KFSCC staff.

assessments or provide formal lessons because this could be adverse to a young person's de-escalation process.

In comparison, the Evaluation noted in the secure care facilities in Victoria, children were provided with a structured education program delivered by a specialist service contracted by the Department – Parkerville College. From Monday to Saturday children were provided with two structured education sessions per day (am and pm). Each day, after education programs have finished the unit staff will then engage with children in a range and variety of activities. This includes cooking, arts and crafts, sport and recreation and creative writing.

The learning and psycho-education activities at KFSCC are considered by management as an important aspect of the service model. The Evaluation acknowledges that KFSCC implements a number of brief interventions around sexual health, protective behaviours, substance misuse, and nicotine. However, the efficacy/effectiveness of these is not currently tested through a pre/post approach during a child's admission. Consultations with District staff suggest a view that children do gain something from the activities. Children's views on many of the activities seemingly depend on their age and experiences. In one interview conducted for the Evaluation, a young person noted that "there is not much to do there but watch tv" and observed that over time (they had multiple admissions), there were lots of "feelings stuff" and not so much school work. Comments in feedback forms completed by children on exit from secure care do suggest some influence from the emphasis on self-care, anger management and protective behaviours. For example, in response to the question "what is one thing you will change for the better after you leave secure care" some comments from children included:

"That I won't smoke, runaway or cut anymore" [redacted]

"Stop getting into trouble, staying safe" [redacted]

"No more being naughty - so will try and take time out in different situations / feelings" [redacted]

"Don't get angry, just walk around instead" [redacted]

"Me making better and good choices and saying no to people that making bad choices" [redacted]

"Staying where I am put and be more safer with myself" [redacted]

"My positive self talk will increase" [redacted]

"Not hang out with the wrong people, stay at home, go to school, listen to my teachers" [redacted]

2.3.2.5 Sanctuary Model and Therapeutic Crisis Intervention

The KFSCC service model is described as trauma informed, underpinned by the Sanctuary Model and Therapeutic Crisis Intervention (TCI). The core principle underpinning TCI is that resolution of a child's crisis depends on the environment and care worker's therapeutic and developmentally appropriate response. TCI involves strategies for staff to use on an ongoing basis to prevent or intervene in response to crisis situations. The TCI system teaches and supports strategies for care workers to:

- Assess children's aggressive behaviours as expressions of needs.
- Monitor their own levels of arousal.
- Use non-coercive, non-aggressive environmental and behavioural strategies and interventions that de-escalate the crisis and that lead to the children's own emotional self-regulation and growth.

- Use physical interventions only as a safety intervention that contains a child's acute aggression and violence. [57]

TCI has been reviewed by the California Evidence Based Clearinghouse for Child Welfare (CEBC) through their Scientific Rating Scale process. The CEBC has determined that the TCI program currently lacks the type of published, peer-reviewed research that meets the CEBC criteria for a scientific rating of 1 – 5. Therefore, the program currently has the classification of "NR - Not able to be Rated."[58]

Sanctuary was selected as the preferred model for Therapeutic Care Services in WA in 2012. Sanctuary is not an intervention but an organisational way of working involving practice principles. It is based on a recognition that services (organisations and their staff) can be traumatised by the nature of their work and that an organisation's ways of working need to align with the therapeutic care provided to clients. It is designed to improve client and staff outcomes through building a shared language, vision and commitment to change. The CEBC Scientific Rating scale accorded Sanctuary a level 3 'promising research evidence' due to the fact that there is at least one study utilising some form of control that has established the practice's benefit over the control.[59]

Factors related to successful implementation of evidence-based practices in residential settings include training, supervision, and feedback. In addition, the need for organisational 'buy-in', commitment and leadership as well as consistency.[60] Implementation of Sanctuary at KFSCC confirms the importance of many of these factors in the effective implementation of the program. The Evaluation observed that there is a strong commitment from KFSCC Management to the Sanctuary Model and a belief in its efficacy with children at the centre. Certainly, the principles and approach within Sanctuary appear to provide KFSCC staff and management a clarity of purpose and a means of ensuring a particular focus that is designed to contribute to a sense of unity and uniformity in the functioning of the centre.

Staff surveys highlight a perception of Sanctuary and TCI as enabling staff to have an effective response to children's complex needs and contributing to good outcomes for children while in secure care. Comments included:

> *"The application of the Sanctuary Model and Safety, Emotional, Loss and Future (S.E.L.F) framework are key to most children's success and improved outcomes"*
>
> *"Sanctuary and trauma-informed model that gives staff tools and knowledge to better support the children"*
>
> *"TCI and Sanctuary provide staff and children with a positive culture which has a direct impact on the service provided. The consistent one-on-one work with the children allows them to build positive relationships and as they are unable to leave/runaway when confronted with certain issues the children are able to go through the conflict and the process of rupturing and rebuilding relationships".*

A District Director acknowledged that Sanctuary has played an important role in implementing significant change in Communities approach to residential care and secure care and suggested that it

[57] http://rccp.cornell.edu/tci/tci-1_system.html

[58] http://www.cebc4cw.org

[59] http://www.cebc4cw.org

[60] James, S., Thompson, R. W., & Ringle, J. L. (2017). The implementation of evidence-based practices in residential care: Outcomes, processes, and barriers. *Journal of Emotional and Behavioural Disorders*, 25(1), 4-18.

would be good to review the Sanctuary Model's relevance and suitability, given the length of time since it had been introduced.

2.3.2.6 Admission of children under 12 years of age

Consideration of the appropriateness of the secure care admission criteria and the service model necessarily involves the situation with regard to children under 12 years of age.

Out of the records for 219 children admitted to KFSCC between May 2011 and 30 April 2018 for a total of 418 admissions, 40 children were aged under 12 years at the time of first admission (two aged 7 years, three aged 8 years, seven aged 9 years, twelve aged 10 years and sixteen aged 11 years). There was a total of 59 admissions for children aged less than 12 years over this period.

The average total period spent in KFSCC for this cohort was approximately 44 days (which is similar to those who had a first admission at 12 years or over (41 days), and an average of two admissions, again similar to the older cohort on first admission (see Figure 2.11). Of the 59 admissions, 20 were extended (45%), which is significantly greater than for the older cohort (22%). Of note is that there were a higher proportion of males in the younger cohort[61]. There was also a higher proportion of country referrals which is in part due to a number of siblings being admitted, [redacted] from regional Districts. Only two of the under 12 years of age cohort were identified as having a disability, [redacted]

Twenty-nine children (73%) were identified as either Aboriginal or Torres Strait Islander, which is significantly above the total KFSCC cohort (55% identified, Chi-square p <0.05) with all of the 7 and 8 year olds being identified as ATSI. Eight went on to have placements at Banksia Hill Detention Centre, with the range being from one to 13 periods in detention, with an average of five. This is slightly less than the older cohort with only 35 per cent having a period at Banksia Hill, and the range being from one to 14 periods in detention, and an average of three.

[61] Of the total cohort analysed (219 children admitted during the period, 118 or 53.9% male), for those under the age of 12 on first admission (40 children – with 35 males - 87.5 %)
Statistically significant (Chi square of 15.8114, p<.001).

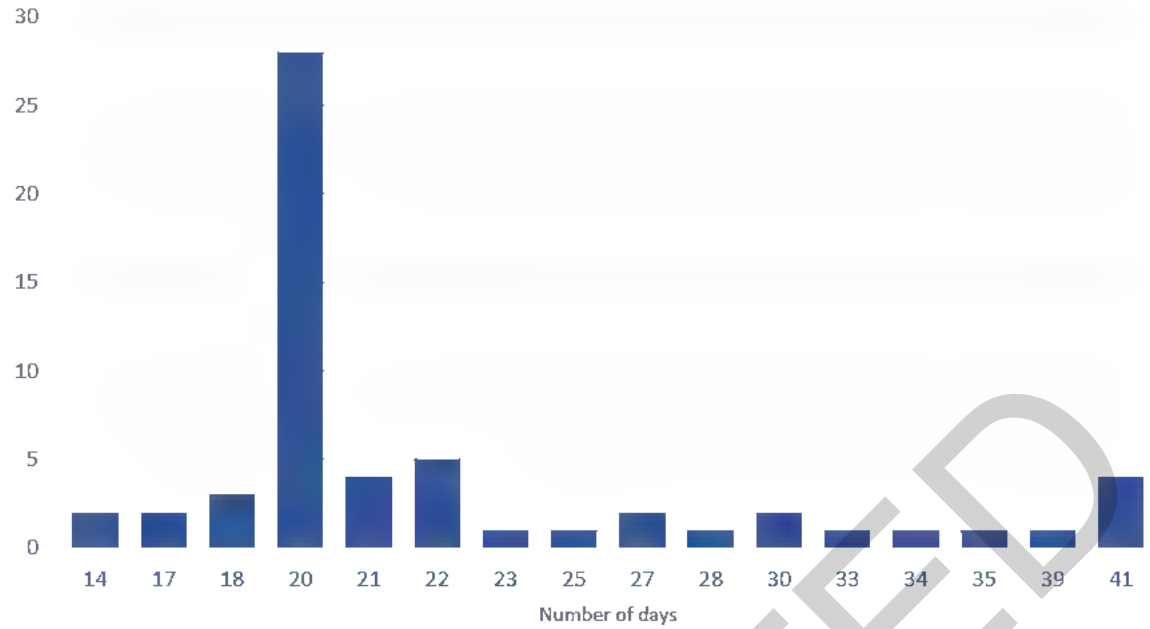

Figure 2-8: Length of stay (days) for admissions of children under 12 years (May 2011 to April 2018)

Stakeholders and District staff consulted for the Evaluation expressed concerns about the need to refer children under 12 years of age to secure care but acknowledged the very limited options for under 12 years old with extremely complex needs, and especially in the regional districts. It was recognised by all consulted that this is an especially high needs group who can be at even higher levels of risk because of their impulsivity and lack of real understanding about the consequences of their very unsafe behaviour. Those who have been working in the sector for some time believe the complexity of some children's needs and their levels of comorbid behaviours has increased from that seen 10-20 years ago. They regard this as affecting all age groups although definitely is observed in younger children coming into care who demonstrate extreme trauma, the effects of intergenerational trauma, and have alcohol and substance misuse problems.

The figure below shows the trends in age at admission for children under 12 years of age, and for comparison, those in early adolescence (12 – 14 years) and adolescents (15 years and over) over the course of KFSCC operations. From 2013, when the first child aged under 12 years was admitted, the data indicate an increasing level of admissions of this cohort to 2015 which subsequently stabilised in ensuing years. The trend for children in early adolescence has been relatively stable while the number of admissions for adolescents has shown a recent decreasing trend.

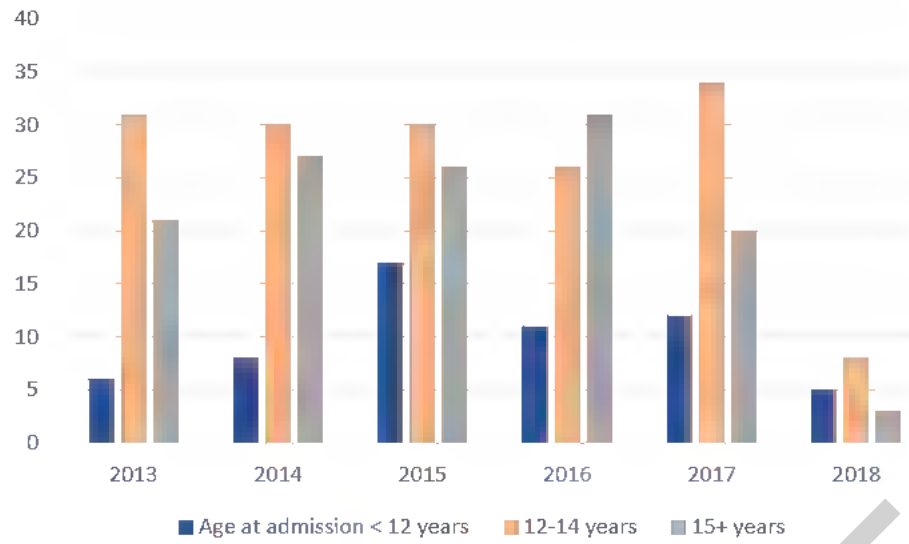

Figure 2-9: Age at admission (7-11 years; 12-14 years, 15+ years) by year of admission (2013 - 2018)

Consultations with District staff and external stakeholders confirm children under 12 years do meet the criteria of being at extreme risk and have no other options to ensure their safety. There is also a view among District staff and KFSCC staff and management that some of the more "successful" and responsive children are among this cohort. A remote based District Director described how young children respond well to the activities, safety, routine, opportunity to play and access regular meals and have continual adult attention. KFSCC Staff surveys for the Evaluation reflect similar views. Comments include:

> *"Generally the younger cohort of children are more open to new experiences and ability to feel safe and allow themselves to be a child while at Secure Care. The younger children are less self determined and more able to see a positive future for themselves with support."*
>
> *"Younger children love the security and structure, and feel safe."*
>
> *"I think early interventions are better for younger children, to provide a circuit breaker for unsafe behaviours. Children at age 14/15 are more set in their ways and can struggle to adapt."*

The staff online survey asked the specific question of "[T]hinking about the children you have worked with during your time at Kath French, does your approach differ for children under 12 years of age (if applicable)?" and 50 per cent (ten respondents) indicated that they did, with 30 per cent (6) indicating 'sometimes'. Most respondents provided comments about how they individualised their interactions with all children and acknowledged that age appropriate interactions and activities were provided according to 'developmental needs', with consideration of intellectual development. A respondent commented on the needs of the younger cohort for "appropriate placement, intervention and nurture" being greater and need to be responded to so as to "prevent an escalation of their trauma". The same respondent considers that "[Y]ounger children generally respond really well (and more quickly) to the program at Secure Care."

As part of the semi-structured interviews carried out with those who were previously admitted to secure care, a stimulus question of "tell me about your first trip up to Kath French?" was asked. Of those children asked about their experience of being transferred to the secure care centre who, at the time of their admission were under 12 years of age, one interviewee commented that the trip was "really scary, and thought I was going to be murdered in the bush", after being apprehended by Police

in the early hours of the morning in the city after absconding from her residential care placement and a referral being accepted for admission to secure care. The child went on to have subsequent admissions to secure care but vividly recalled not understanding where she was going or why for this first admission. She also commented that while it "took her a few days" on this first admission to settle down, in hindsight she thought that she should have been allowed to stay for a longer time on this first admission (this admission was 21 days and was not extended). In contrast, another interviewee commented that they "fell asleep" on the way and woke to find themselves up in the hills.

As mentioned earlier, secure care was not intended for children under 12 years of age and yet a steady number of admissions into KFSCC do occur for this cohort. In light of this, the Evaluation is of the view that every endeavour should be made by Communities to explore alternative accommodation arrangements (to that of secure care). Alternative approaches might consist of admitting the child into a high support/needs placement[62] (with a developmentally appropriate cohort, with high levels of supervision, appropriately trained and experienced staff and an age-appropriate accommodation environment). Such placements would be the preferred approach unless extenuating circumstances exist, that placement into secure care is in the best interests of the child.

[62] Communities currently have arrangements in place (referred to as a High Needs Placement) which can be organised for children and young people with high needs, a disability or who are part of a sibling group. Communities "Transitional High Needs Program caters for children and young people with extremely complex behaviours and high needs who often pose a risk to themselves and the broader community. These placements provide individualised and specialised care." (Refer page 88 of the Department for Child Protection and Family Support Annual Report - https://www.dcp.wa.gov.au/Resources/Documents/Annual%20reports/Annual%20Report%202016%202017%20Online.pdf).

Case Study: [redacted]

[redacted]

When asked about [redacted] first admission [redacted] didn't understand why [redacted] was being taken away from [redacted] residence and thought "why me?" when the police came to pick [redacted] up. [redacted] remembered that [redacted] was a bit confused at first and then thought that it was "boring and hated it".

[redacted]

During the interview, [redacted] identified that [redacted] loved the food and the "trampoline, playing soccer and dodgeball' were the things [redacted] liked to do but [redacted] didn't like the building and thought there should be more things to do. [redacted] thought that [redacted] felt "safe" sometimes although it "depended on who was here". While [redacted] was happy to complete the rating scales sheet to address the questions about secure care [redacted] was reluctant to discuss [redacted] responses in much detail. [redacted] did admit the food was perhaps the best thing about Kath French. The things [redacted] didn't like about secure care was "some of the staff" and, sometimes, some of the other kids. [redacted] understood that when [redacted] secure care arrangement ended [redacted] would be returning to the [redacted] and wasn't upset at the prospect.

* not [redacted] real name

2.3.3 Summary

The Evaluation has found that the admission criteria is appropriate for identifying children with extremely complex needs, at an immediate and severe level of risk and whose situation requires intervention through the provision of removal and security. Prior to their secure care admission many of these children are engaged in a cycle of absconding, a range of harmful and extreme behaviours, involved with the Police, attending Emergency Departments, harming themselves, and sometimes being admitted to a mental health in-patient facility. For these children and their caseworkers, there are no other options for ensuring safety. In such cases, secure care is, in fact, the only option. Secure care is also regarded by stakeholders outside of Communities as absolutely necessary for a particular group of children because there is a complete lack of alternative options, including mental health facilities, where the safety of the child can be ensured for any length of time and their needs can be met.

The consensus among stakeholders was that the safety provided by the secure facility was effective for addressing many children's immediate needs and levels of risk because it removed them from so many of the sources of their risk behaviours and gave them some time to deescalate. For children requiring this level of containment secure care can be seen as a 'circuit breaker'. However, as many of those consulted also acknowledge, some children's extremely complex needs are such that they quickly resurface after exiting secure care resulting in a strong likelihood of their return to dangerous risk levels sometimes requiring further admissions to secure care.

The Evaluation notes that the service model is designed around meeting each child's needs and providing activities that are engaging and not causing stress for a child. That said, there is a definite emphasis on play in the content of many activities that cater to younger children. Children in secure care, especially older children, require meaningful activities and learning programs which serve to promote their self-respect, foster their sense of capability and resilience, and support the development of life skills and attitudes especially around education, that will assist them in successfully reengaging into the community.

Consideration of the appropriateness of the admission criteria and secure care service model in responding to children with extremely complex needs inevitably includes the length of time a child is in secure care. The average stay of 18 days for children at KFSCC, is, in the view of most stakeholders, necessary and, for some, an effective, albeit often short lived, circuit breaker. While some children might stabilise in less than 21 days, and KFSCC staff recognise the improvements many make by week 2, all District staff consulted for this evaluation regard 21 days as necessary for almost all children's level of need and, in most cases, is in their best interests.

The process associated with reaching a decision on whether the legislative criteria/threshold for admission has been met, incorporates an element of interpretation. In such instances, a conservative approach should be applied that acknowledges that no child should be deprived of their liberty unless as a measure of last resort and then for the shortest appropriate period of time. The lack of consistent and mandated individual advocacy for children admitted may also be a factor in the admission length.[63]

The Evaluation notes that the Sanctuary Model currently underpins the therapeutic approach to children in secure care. While acknowledging the value of having a trauma-informed approach, the training in the Sanctuary Model is not considered sufficient preparation for managing the many mental health needs of the children admitted to KFSCC which, while predominately thought to be trauma related, cover a wide range of mental health conditions. The Evaluation acknowledges that the Sanctuary Model, and potentially secure care, can provide an opportunity for commencing an individual trauma intervention in a structured and supportive environment. However, the Evaluation also concludes that, at this stage, the Sanctuary Model does not meet the threshold of a specific trauma-focused intervention for post-traumatic stress disorder or other mental disorders. Rather, the *Australian Guidelines for the Treatment of Acute Stress Disorder and Post-traumatic Stress Disorder* recommends that "for children and adolescents of school age with PTSD, developmentally appropriate trauma-focused cognitive behavioural therapy should be considered".[64] Furthermore, the most recently published guidelines from the National Institute for Clinical Excellence recommends trauma-focused cognitive behaviour therapy for the treatment for PTSD in children and young people.

[63] Commissioner for Children and Young People WA 2017, Oversight of services for children and young people in Western Australia, Commissioner for Children and Young People WA, Perth

[64] https://www.phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-Child-Practitioner-Guide.pdf) and again the recommendation is individual rather than group (but they suggest parent involvement

Regarding chronic paediatric post-traumatic stress disorder, the guidelines suggest incorporating 8–12 weekly sessions, delivered in a consistent manner by the same person. Therefore, the need for a dedicated specialist mental health service, provided by the Department of Health and Mental Health Commission, for children in care in the State is required, and the need for secure care staff to have knowledge of mental health presentations in children is evident (Refer to Section 0 in this Report).

2.3.4 Recommendations

Recommendation 4 - Consideration be given to formalising a process of review (at ten working days) in a secure care arrangement in conjunction with an independent person/body to reassess the extent to which the child still meets the admission criteria.

Recommendation 5 - The completion of "youth mental health first aid" or similar training be a compulsory component of staff induction to KFSCC.

Recommendation 6 - Consider introducing a structured therapeutic planning document with a set of guidelines that specifies particular programs/modules (e.g. evidence based, culturally appropriate, etc.) to support the delivery of tailored/diversified brief interventions.

Recommendation 7 - Consideration be given to developing daily activities, as the site permits, to better support the needs and circumstances of older children at KFSCC especially with regard to enhancing independent living skills, supporting positive resilience and coping strategies.

2.4 What are the current barriers to transitioning children safely from secure care?

This section explores the effectiveness of steps and measures designed to address the child's needs and reduce the likelihood of the child being re-admitted.

2.4.1 Method

The following methods were utilised to examine the current barriers to transitioning children from the KFSCC.

- Document review: includes CCSA, Second Reading Speech, *Policy on Children Entering Secure Care*, KFSCC Tip Sheet, Statutory Review on Children and Community Services Act (2004), *Review of the Kath French Secure Care Centre – Under 12 Year old Cohort*, *Casework Practice Manual*, KFSCC Assessor Reports, *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre*.
- Consultations with stakeholders including District staff.
- Correspondence with KFSCC Management.
- KFSCC staff surveys.
- Children's feedback forms.
- Desktop review of relevant literature and published research.
- Interviews with children and carers.
- Case file and ASSIST data reviews.

2.4.2 Findings

2.4.2.1 Transition practice into and on from secure care

Planning for a child's transition from secure care to their next placement (including a return to the previous placement) commences at admission. The *Casework Practice Manual* states:

- All exit and transition care planning, funding, services, referrals and actions should be documented and recorded as part of the secure care initial care planning meeting.
- The District retains responsibility for the development and implementation of the child's transition plan.
- All stakeholders are involved in planning for the transition and child protection workers are responsible for the distribution of all case material to other parties involved in the child's transition plan.
- An exit planning meeting should be held within the last week before the child leaves the secure care facility.
- Continuity and support are provided through case management by the District. Secure care staff collaborate with all stakeholders to ensure that the transition occurs as seamlessly as possible and may be involved with follow-up support as necessary/required.
- The child's personal property, which includes all personal belongings such as money and personal or valuable items are to be returned to them and signed for at the point of exiting the secure care facility.

Placement data provided by Communities from the ASSIST database to the Evaluation for the period 31 May 2011 to 30 April 2018 shows a trend for children exiting secure care to placement in more intensive arrangements, and a shift from country residential services to metropolitan.

Table 2-4: Pre- and post-admission placement

	Living Arrangement Before	Living Arrangement After
Residential Care	194	213
Safe Places*	24	68
Detention	39	11
Family Carer	17	32
General / Specialist Foster Care	16	14
Hospital	15	7
None	16	1
Runaway	22	4
Significant Other	5	2
Unendorsed§	44	42
Unknown	10	3
Other‡	16	21
TOTAL	**418**	**418**

* Note, Safe Places is categorised as residential on ASSIST

§ Unendorsed refers to living arrangements that Communities have not yet assessed or approved. For older children, this may be due to self-selecting the placement. All placements are assessed for suitability. There may be situations where an assessed family member is recorded on ASSIST as unendorsed pending an approval.

‡ Other includes the following categories: At Risk Youth Accommodation, Fee for Service Group Home, Group Home, Independent Living, Professional, Roster Model Support Service, Specific Child, STAY, Supervised Bail, Supported Accommodation

2.4.2.2 Barriers

A critical factor in a child's effective transition from secure care is their capacity to sustain and build on outcomes achieved during secure care, especially their stabilisation and regulation. Research suggests that although children may improve during a secure care arrangement, this is not necessarily a good predictor of long-term outcomes when they exit the facility.[65] A child's transition process, specifically the post secure care support, is considered to be just as critical to their overall progress.[66] This is largely dependent on the suitability of the environment into which the child is placed and the supports they can access. As the Statutory Review notes, if these are not able to be provided or are

[65] Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*, 71(2), 227.

[66] McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, Australia; Moodie, K. (2015*). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice*

delayed, then there is a potential for the breakdown in the child's placement causing a return of risk levels that can lead to readmission.[67]

As noted previously, between 31 May 2011 to 30 April 2018 there were 88 children with multiple admissions to secure care. Twenty-three children had more than three admissions with one child having 20 admissions. This suggests that there are breakdowns occurring for some children and that the intention, as stated in the Second Reading Speech, of "reducing the likelihood of another period of secure care in the future"[68] is, for some children, not easily achieved.

Thematic analysis of the consultations with stakeholders and staff, and interviews with children highlight a number of barriers to the effective transitioning of children from secure care. These barriers are:

- limited suitable placements available
- more time required to find a placement
- no step down service or specific placement options from secure care
- uncertainty about next placement disrupting child's stabilisation on exit
- impact of the contrast between the secure care environment and the next placement
- keeping Aboriginal children off country and adding to trauma levels and placement breakdown
- limited support services especially in regional areas
- lack of inter-agency collaboration for planning a child's reengagement and support.

Some of these barriers are explored in more detail below.

Availability of suitable placements

Many stakeholders commented that children's stabilisation in secure care cannot be sustained for any length of time if they are then exposed on exit to circumstances and environments that easily trigger their risk behaviours. There was a consensus among those consulted that there are very limited placement options for most children transitioning out of secure care. Consultations and KFSCC staff surveys highlight a perceived lack of availability of suitable placements for children with extremely complex needs. This is regarded as contributing to the admission to secure care, the quick return to heightened risk levels on exit from secure care, and in some cases subsequent readmission/s.

Some District staff identified the major barrier as a lack of options, especially high needs transitional placements. One District Director suggested that around one in ten children exiting secure care from their District would generally access a high needs placement, even though nearly all required such a placement. This person also spoke of the lack of placement options for children who had exited secure care in the last 12 months with seven of those children described as "really struggling" and returning to very high-risk behaviours. District Directors from the regions spoke of having no option but to bring children back to a residential group home in the region if they could not access a high needs placement. The view was that the residential homes are generally not able to accommodate the needs of children coming from secure care. They described one child who absconded from a residential home within ten minutes of being placed there following secure care.

[67] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia, p.84

[68] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr A. J. Simpson, p6962b-6991a

Comments regarding the lack of placement options included:

> *"I see the barriers as being mostly about the lack of placement options that are suitable for children that have had problems of the severity that required Secure Care. We have NONE that can be brought on line in a timely way. I will forever recollect the road blocks over many, many weeks in trying to configure a 1:1 placement for a child coming out of Secure Care..." (Clinical Psychologist,)*

> *"There are often a lack of stable and quiet placements for these children who need strong boundaries and therapeutic care – the residential care homes can be quite volatile with a range of teenagers moving in and out." (District Team Leader)*

With regard to readmissions, one KFSCC staff member commented:

> *"Whilst they may have made therapeutic gains at KFSCC, if they return to a similar situation then the external pressures remain and are too strong to resist... Lack of appropriate recommended placements, and limited transition opportunities impact significantly".*

Some of those consulted indicated that an 18-21 day secure care arrangement equated to far less actual working days and thus the time available to prepare for a child's transition, especially identifying a suitable placement. District staff described that the lack of placement certainty also meant that planning for support services following a secure care arrangement was challenged by the fact that most support service providers (Government or NGO) will require an address for the child before they will commit to a referral. District staff spoke of needing greater involvement from other government agencies at the planned review meetings with secure care, particularly those at the commencement of a stay, in order to achieve more positive outcomes for children.

Some consulted were critical of the unit within Communities responsible for placement and accommodation of children – referred to as the 'hub' - and found it perplexing that a child's next placement could still be unknown hours before they were leaving secure care, despite the fact that there had been nearly three weeks to prepare for this. It was explained to the Evaluation that there is a ten day tendering process for a high needs placement for a child (which impacts on the ability to implement early discharge recommendations) and, if this was unsuccessful there was little time and option for where the child might go. One District staff member commented:

> *"[we] need Departmentally managed residential homes to transition children into from Secure Care. For me, this is a very big issue. I do not think **simple** referral to NGO's and waiting for them to express an interest in taking on child in severe need is working."*

Distance

Regional and remote Districts face further challenges in determining a suitable placement option for children, especially given the absence of high needs placements in many regional areas. Many have to contend with the decision to keep children away from their community to access a more intensive placement and the risk this poses to the breakdown of the placement. It also means challenges for caseworkers to maintain contact and responsibility for the child. One District Director spoke of the number of children residing in their district in high needs placements who are case managed by another District and the challenges involved in managing these cases where issues arise. Co-case worker arrangements between Districts can be put in place, however, because of the higher workload children with complex needs involve, this was often not sustainable for the local caseworker and incurred resources from the local District's budget.

Impact of exiting the secure care environment

A submission to the Statutory Review from a District Office acknowledged secure care as a time of safety and care for a child but also one of uncertainty and fear because their next steps are often not clear. Many of those consulted for this evaluation identified the uncertainty about some children's next placement as negating an effective transition process. As noted above, a child's next placement may not be known until hours before they are due to leave the centre and the Evaluation was told of children sitting in secure care with their belongings waiting to be transported to the next placement with no knowledge of what type of placement it was or where.

KFSCC staff identified uncertainty about a child's next placement as detracting from the work they do with the child while in secure care. One staff member commented:

> *"In many cases there is no actual transition due to the lack of placement opportunities for children. Thus, many children do not have definite information until the actual day that they leave. This is distressing obviously for the child, but also for the staff who are trying to support the child to leave in a positive mind frame and to build on any gains that they have made."*

There was a consensus among those consulted that another barrier to a child's effective transition from secure care is the difficulty some children experience leaving the secure care environment including the immediate cut off from KFSCC staff, loss of one-to-one modelling and co-regulation of emotions. Many identified the challenges for children experiencing such a stark contrast in leaving the secure care environment, which was described as "not real" and a "bubble" by District staff and others. The routine, safety and individualised attention the child accesses whilst in secure care cannot be sustained in other placements to the same extent. Even high needs placements do not always prove successful in ensuring a sense of continuity from the secure care environment.

One stakeholder stated that what many children need and want after secure care is access to ongoing relationships such as with a mentor, youth worker or adult external to Communities. They noted that the relationships children form during secure care is what many children value and which provides a great deal of stability and it is these types of relationships that can be difficult to access in subsequent placements. They noted that the desire for stable relationships is a critical issue for many children in OoHC who can often experience multiple placements, caseworkers and carers.

The *Policy on Children Entering Secure Care* states "[S]ecure care staff collaborate with all stakeholders to ensure that the transition occurs as seamlessly as possible and may be involved with follow up support as necessary/required." The Evaluation was informed that very limited formal follow up takes place. KFSCC Management were clear that transitioning and follow up care are not their responsibility. The staffing model does not have the flexibility to involve significant post-stay support, however, support is offered to stakeholders whenever appropriate and possible.

The *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre* notes that the majority of child protection workers consulted had identified "room for improvement" with regard to the transitioning of children from KFSCC. The 2012 evaluation identified not enough engagement of the secure care staff in the process of identifying the best placement for the child after secure care. Similarly, some stakeholders consulted for this evaluation suggested that it would be beneficial to the transition process if the KFSCC staff were more involved in the transitioning process of a child. This suggestion was largely related to the important relationships many children form with staff and the sense that this could assist children in responding to the next placement. KFSCC staff surveys highlighted a view from some about perceived benefits for the child if there was more follow up with the child after secure care. Comments included:

"More joined up discharge process. It would be great if staff (key staff) could be involved in follow up of child"

"Having Secure Care Officers transporting the children back to placement as we pick them up to seal the relationship on exit".

Many consulted for this evaluation identified the need for children in secure care to have more opportunities to transition into the next placement in a gradual way to allow for them to adjust prior to their exit. In those situations where the next placement is known, KFSCC Management cannot allow children to participate in transitional visits while still under their secure care arrangement because the CCSA does not expressly enable this to occur. The Statutory Review identified the need to amend the CCSA to address this limitation and recommended that the CEO be able to remove a child temporarily from the facility[69]. This does not prevent future staff or carers from visiting and spending time with the child at KFSCC, which does occur. Such arrangements are not possible in circumstances where the child's placement remains uncertain throughout most of their stay.

Research on placement planning for children in care, and relevant stakeholders consulted for this evaluation, highlight that children's involvement in planning their next placement is important. Child participation in decisions affecting their life is an important principle set out in section 10 of the CCSA and a human right articulated in the Convention on the Rights of the Child. The uncertainty many children experience because of an apparently not uncommon scenario of not knowing where they are going days or, in some cases, hours before they leave secure care, would suggest many children are currently unable to meaningfully contribute to those decisions.

Lack of step-down option

Many stakeholders suggest there is need for a staged or step-down approach to transitioning children from secure care. This is regarded as addressing the negative response many children have in transitioning from the level of containment, routine and intensive staff attention, modelling and coregulation they received at secure care to their next placement. The survey of child protection case workers for the *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre* showed support for staged transitional arrangements where some aspects of the care received in secure care was continued. The report notes a "strong sense" among the case workers that a transitional placement would benefit the young person "if the 'practice overlap' between the secure centre and the next placement could be further enhanced".[70] Surveys with KFSCC staff undertaken for this evaluation highlight similar proposals. Comments included:

"a transitioning out of the Kath French Centre may make the change of environment not feel so sudden."

"it would be good for some kids to have an interim transitional house - possibly on premises for them to stay for a few weeks as often the department struggle to find suitable premises straight away. More External agencies (Not for profit etc.) to visit and offer alcohol and other drug/ counselling services."

"Ideally - a program which trials the child's ability to be safe outside of Secure Care would be beneficial. Sometimes, the sudden change from being locked away to being completely free can be overwhelming and lead to unsafe choices."

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[69] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia, Recommendation 26.

[70] Department for Child Protection, 2012 Study of Caseworker Experiences Kath French Secure Care Centre. Perth, Western Australia p.9

"Children that come to the Kath French Centre appear to thrive in the structured environment, however the environment here is different to the real world and potentially having some slight transitional steps may help e.g. half day outings."

"1. Stage One Secure Care Arrangement with open ended placement depending on child's progress on trauma recovery. 2. Stage Two Transition House-outside Secure Care with a minimum of Three weeks placement. Stage Two would be very crucial because if child's safety issues continue to be a concern, readmission to Secure Care would be logical unlike what is happening now where children exit Secure Care despite not achieving anything. 3. Stage Three back to family or Department's House."

"Many children would benefit from step down acomadation (sic) still under the management of KFC [Kath French Centre] where they are in a controlled environment allowing further work to be done in a one on one or small group situation"

"Occasionally the children are not ready to re-engage in the community safely. It would possibly be a good idea to have an addition to the centre where young people are able to stay in a secure environment but have day trips out to places such as school and doctors and appointments".

"A step-down model that allows for more considered and planned transition to the community - greater availability of outreach services and resourcing so that children can be engaged with services whilst at secure care that will follow them in to the community."

In rare instances, children in care exiting Banksia Hill Juvenile Detention Centre who are deemed not stable enough to enter the community and for whom there are no options to address their needs are referred to secure care. While these children meet the admission criteria, consultations with relevant stakeholders suggest these admissions might be avoided in some cases if there were other options available that met the gap between a therapeutically based secure care environment and residential care placements. One stakeholder described how the stability children gained whilst in secure care was difficult to achieve in juvenile detention, however the period of secure care was not long enough to adequately prepare children for a more successful reengagement into the community. [redacted]

The Statutory Review notes that Communities considered a step-down approach in the development of its new out-of-home care service system, including a model of complex care for high needs children. However, the feedback the review received during consultations undertaken at that time highlighted concerns with the potential for such an approach to result in multiple care arrangements that would be against a child's best interests. The Statutory Review noted the importance of "building-in greater contractual requirements for Care Safety Officers to work with secure care from the point of a child's admission, in order to facilitate the transition of children back into community placements".[71]

[71] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia,p.76

Accessing Support Services

Many of those consulted regarded a child's readmission to secure care as the result of a number of factors including placement breakdown, a lack of access and/or not accessing the services they need to maintain stability and regulation, and the challenges some children face in avoiding harmful environments, behaviours and peers/family. The discharge summary from KFSCC indicates what services children may require which is the responsibility of the case worker to progress. However, as indicated elsewhere, the availability of services appropriate for children with extremely complex needs presents a number of challenges to their needs being met.

One KFSCC staff member noted:

> *"Children present to KFSCC in a state of crisis, requiring stabilisation and safety. Secure care provides a short circuit breaker to assist in building safety and emotional regulation for that child, however the timing does not allow for processing of deep rooted trauma issues. As such, when the child is faced with stressors and triggers in the community the same behaviours and emotions are likely to resurface. Children who re-present to secure care, anecdotally, appear to experience a cumulative effect of the work done at Secure Care. If the underlying issues aren't treated then the same issues will come up again and again. There is also a paucity of therapeutic services that are willing to work with this population of children, with many gaps in placement availability, mental health and justice systems".*

The *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre* notes the cases with the most sustainable outcomes after secure care had a comprehensive plan for discharge in place prior to admission.[72] Consultations conducted for this evaluation highlight a view that the discharge summaries from the KFSCC are considered comprehensive and a very useful document. However, as many noted, the discharge summary and care planning for children is not effective if the placements and support services are not available or accessible. Similarly, current arrangements mean planning can only indicate the child's specific needs, it cannot link the child to those services prior to their exit. Regional and remote areas in particular face the additional challenges of limited services available for children with complex needs.

There were also concerns raised by some in the Districts that the lack of assessments undertaken at secure care inhibited the planning process. Accurate and up to date information about the mental health of a child with complex needs is important for effective service planning and to ensure their needs are met in their transition from KFSCC. As noted, children may exit secure care without a basic mental health or basic cognitive assessment undertaken which might be beneficial for forward planning.

Lack of certainty about a child's next placement was seen as detracting from planning for the supports and services the child will need including education and mental health. District staff spoke of many children discharged without a current/relevant Documented Education Plan, often because their location is uncertain, and the process of re-engaging them with education can only commence once they have left secure care. Some also suggested that planning for a child's education needs can be a secondary consideration because so much of the District's focus was taken up with identifying an appropriate placement in time. The Casework Practice Manual states that every child in the CEO's

[72] Department for Child Protection, 2012 Study of Caseworker Experiences Kath French Secure Care Centre. Perth, Western Australia p.9

care, of compulsory school age, must have a bi-annually reviewed Documented Education Plan that informs the education dimension of their care plan and reflects their education and wellbeing needs.

In the case file reviews undertaken for the Evaluation, it was observed that around half of the children had a current Education Plan and usually none in the 12 months before admission to secure care. From summary data of the secure care admissions from January to 30 April 2018, five of the 16 children had an Education Plan recorded after their secure care arrangement. Of these, three had no previous Education Plans recorded in their files and three had an Education Plan recorded in their files in 2017. Another three admissions had an Education Plan recorded in 2015, one in 2014 and three in 2017 - with none of these young people having an Education Plan recorded after secure care in 2018. It should be noted that recording the Education Plan status is reliant on case workers completing the required field in ASSIST. Also, the relevant schools where a child/young person is enrolled are responsible for completing the Education Plan so, if the young person is not attending school, there is unlikely to be an Education Plan in place. Consultations with Communities education staff highlighted that the absence of an education plan on a child's file did not indicate a lack of activity. Rather, staff were continuously problem solving and attempting to put in place the most appropriate approach to facilitate children's sustained reengagement with education. These efforts were often challenged by the lack of certainty regarding a child's placement, and in cases where the placement broke down.

The *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre* notes access to ongoing mental health services for young people had a significant impact on whether positive outcomes achieved in secure care could be maintained.[73] Similar views were expressed by some District staff during the consultations for this evaluation. One District Team Leader commented:

> *"There is a real confusion about mental health services for young people – it's a constant struggle for case managers to link children and young people to appropriate services."*

For those children who meet CAMHS criteria, services are largely offered as outpatient facilities through the CAMHS community team and are reliant on the child being brought to their weekly appointment. Once a child has missed a certain number of appointments they are discharged from the service. For children who do not meet CAMHS criteria there is very little else available. The Statutory Review suggests one response to this issue is to provide for "the funding of individual children according to their NAT [Needs Assessment Tool] assessment to create greater flexibility, efficiency and capacity to meet children's needs, regardless of their care arrangement".[74]

Concerns were expressed about the particular situation of children 17 years of age transitioning from secure care and who no longer meet the criteria of certain services, for example CAMHS, and can be ill-suited to many placement options resulting in no placement able to be identified for them. Many professionals regard this age group as difficult to place with a range of services, including mental health services and residential care. Accessing adult mental health services is viewed as inappropriate for this age group. They are also at greater risk of experiencing homelessness where they are exposed to a variety of risks and may also access homeless services where there is no adult care or supervision.

[73] Department for Child Protection, 2012 Study of Caseworker Experiences Kath French Secure Care Centre. Perth, Western Australia p.9

[74] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia, p.76

Inter-agency collaboration

The Second Reading Speech in the Legislative Assembly notes that "a multi-agency response can assess complex needs and ensure that transition plans are developed and services provided to support the child's return to a suitable placement."[75] The original intention for a multi-agency response to children in secure care reflects an acknowledgement of the need for multiple services and agencies to be involved in planning around a child's complex needs and to reduce the likelihood of their return to secure care. The *Policy on Children Entering Secure Care* emphasises the need for shared responsibility of ongoing service provision after a child leaves secure care. It states, "transition arrangements are most effective when developed collaboratively; they require the ongoing participation and cooperation of other government and community sector organisations."

Consultations with departmental staff and external stakeholders highlight that there is very little multi-agency collaboration taking place to support the needs of children in secure care and plan for their transition into the community. One District Director commented, "the bottom-line is, we need more partner agencies at the table for our young people, it should not just be the District and Secure Care".

The lack of agency collaboration and a multi-disciplinary approach to children in secure care and those who have exited secure care was regarded by some departmental staff as contributing to children falling through the gaps and the rapid breakdown of their placement and return to risk levels. One KFSCC staff member noted:

> *"I think that the overall system (society, child protection, health, mental health, justice) has a number of gaps that children fall through. Agencies appear to work more in silos highlighting what they can't do, instead of recognising the common goal and working collaboratively together. There are examples of agencies working well together of course. Secure Care is another cog in this machine, and whilst we do our best to meet the needs of complex children, there is often a lack of resources available to them whilst they are in secure care as well as in the community. Placements that can meet the child's complex needs are limited which can result in them feeling safer at secure care than in other locations. Being unable to access resources in the community means that the child's underlying trauma is not addressed and they go through a lengthy process of being stuck in a revolving door."*

Many of the concerns raised by those consulted about the barriers to children's effective transitioning from secure care focused on the lack or inadequacies of interagency processes to ensure continuity of the care children require upon exiting secure care. District staff talked of the need for integrated and aligned health, education and social care approaches to children who have experienced abuse, neglect and trauma to improve understanding, recognition, assessment and responses to their needs. Such approaches would assist in preventing issues that can lead to readmission. In regard to education, it is noted that the Department of Education operates the School of Special Educational Needs: Behaviour and Engagement (SSNE:BE) providing services and support for children with extreme, complex and challenging behaviours across the public school system. Accordingly, SSNE:BE is an example of an external service that may be of assistance to KFSCC.

One District Director suggested that a possible way of enhancing inter-agency collaboration could be achieved by providing KFSCC Management with the requisite authority to develop strategic

[75] Western Australia, Parliamentary Debates, Legislative Assembly, 23 September 2010, Hon Robyn McSweeney, p7219b-7221a

relationships and bring senior agency representatives into children's planning and transition processes. Certainly, the value of a formalised process for bringing agency representatives together was identified in the evaluation of the Young People with Exceptionally Complex Needs (YPECN). The YPECN Interagency Executive Committee was well regarded by its members as a forum for developing strong interdepartmental relationships. These were valued not just in the context of YPECN but as promoting greater interdepartmental collaboration generally. This type of committee also provides a mechanism for some issues to be escalated to a level at which they can be resolved. Some of those consulted suggested a need for this approach for some children exiting secure care. While this may not be practicable for all admissions it may be an approach for those children and young people that experience multiple admissions and require more intensive support from a combination of agencies (e.g., Communities and Mental Health Services).

Meeting Aboriginal children's needs

For Aboriginal children who come from Districts outside of the Perth metropolitan area there are additional cultural considerations that must be applied to support their transition both into and out of Secure Care. If they are not returning home, to Country, there are additional factors that must be observed to support their transition out of Secure Care and into placement off Country.

Communities has an Aboriginal Services and Practice Framework 2016-2018 which contains 'foundation elements' that should be looked to when undertaking any planning related to Aboriginal children. The following needs to be considered when undertaking planning and considering placement decisions for Aboriginal and Torres Strait Islander children:

- s12: Aboriginal and Torres Strait Islander Child Placement Principle
- s13: Principle of self-determination
- s14: Principle of community participation
- s81: Consultation before placement of Aboriginal or Torres Strait Islander child (before making a placement arrangement).

The four foundation elements referred to above "provide the broad conceptual understandings that support effective outcomes for Aboriginal children, families and communities. These foundation elements are important in strengthening cultural responsiveness in the provision and development of services, policy and practice[76]", and include:

- cultural respect
- consultation, collaboration and leadership
- self-determination and autonomy
- holistic and strengths-based.

Applying the foundation elements in tandem with the legislative provisions that underpin planning for Aboriginal children, districts with Aboriginal children off country and being transitioned from secure care to a placement still off country have clear parameters to guide the manner in which they meet the cultural needs of the children. Like non-Aboriginal children transitioning from secure care, Aboriginal children can face difficulties in adjusting to their placement and with regard to accessing the supports and services they require, including mental health services. For Aboriginal children however, there can be further challenges due to complex socio-cultural factors, specific culture bound syndromes and the lack of culturally appropriate mental-health services, culturally informed

[76] Department for Child Protection and Family Support (2016). Aboriginal Services and Practice Framework 2016-2018. Perth, Western Australia: Western Australian Government.

therapeutic services, and drug and alcohol treatment services. There are also additional challenges Aboriginal children face in being off country and the negative impact this has on their wellbeing which can impact significantly on their ability to heal and progress in their recovery. As noted above, culturally bound syndromes and considerations like 'longing for Country' and 'being sung' are considerations that can impact children, adding additional complexity. Conversely, Aboriginal children returning from secure care to regional and remote areas can also face enormous challenges in avoiding environments and risk triggers and accessing ongoing supports they may need because of the limited services available to them in their home community/Country.

2.4.2.3 Examples of good practice transitioning

New South Wales

In NSW a graduated 'stepped down' transition model was subsequently developed for young people at the secure care facility after its opening in 2010. The model utilises a combination of secure and semi-secure options to facilitate ongoing support and continuity with the therapeutic approach. This enhances independent living skills and assists engagement with the community. Individual case planning and developing therapeutic goals is undertaken for each young person entering the program. It is through the revision of these goals that determination of a suitable exit plan and timeline for transitioning is determined. Sherwood House is not described as a "secure facility" rather, a residential facility with the capacity for containment. This language is deemed important to the flexibility embedded within the facility and its therapeutic approach. The facility has the capacity to restrict children's outside movement when required as part of the therapeutic response, however, there are different levels of containment, with children able to go out into the community depending on the level which applies to them at that point in time. Some children go into the community accompanied by a carer; some have unsupervised family visits; others have visits with a carer and with security staff nearby. The level of security changes depending on the identified need, which includes asking the child what they need for support in that instance.

The setting of the facility is also considered important to the program. The facility is on 2.5 hectares of land on the outskirts of Sydney. Sherwood House is described as looking like a standard residential group home, with some subtle changes. The house is secured by a perimeter fence, and the cottages are semi-secure, offering a step-down alternative to children as they transition from the unit. All sites offer capacity for containment, via fencing or physical restraint where necessary. A staged pathway to mainstream schooling has also been established as part of the step-down transition, with Sherwood House children attending Sherwood school on site, then progressing to attending half-day or up to three days a week at a local school providing alternative arrangements.

Victoria

The aim in Victoria's SWS is to achieve an integrated service approach to address a range of trauma issues. To this end, partnerships have been established across the service including with Child Protection, Parkville College (education provider), health services and specific program providers. The principal objective of the secure care is crisis stabilisation and to provide children with the means to positively plan their return to the community in a collaborative way with their Care Team. Access to the outsourced psychology service enables assessments or secondary consults to be conducted, as per referrals completed by child protection practitioners. These assessments provide:

- an outline of the current presentation of the young person
- recommendations on required follow up by the child protection practitioner.

In addition, a Health Exit Summary is prepared by the health service prior to a young person's exit, the summary is used to inform child protection practitioners and other relevant services about the young person's health needs to facilitate their ongoing case management. The summary includes:

- an overview of interventions and education and any community referrals needed
- information relating to health conditions, allergies, medication and vaccination history
- Information regarding services accessed during this admission or previous admissions and external supports.

The Transition and Exit Plan aims to ensure a safe move for the young person to their placement. Each young person exiting has a written plan to support them once they are discharged; aimed at preventing further admissions. The Plan incorporates the outcome of any assessments undertaken while the young person has been in secure care. The Plan is shared with the young person prior to implementation and their views noted and incorporated into the Plan.

Scotland

In Scotland, secure care units include a gradual transition from the structure and supervision of secure care towards a less restrictive setting. Transitional care arrangements are in place for those who no longer require containment, but still require additional support prior to them returning to a less structured environment within the community. There are also some semi-independent living arrangements with a focus on enhancing independent living skills. A three year study examining the outcomes of this gradual 'step-down' approach found it was linked to better outcomes. [77]

It is also legislated in Scotland that all young people should have a throughcare and aftercare plan covering a period of at least three months following the day of departure from secure care, to support them in the community as "children in need" under *Children (Scotland) Act 1995*. The legislation also identifies that "a placement in secure care must be part of a planned journey through the care system". The *Children and Young People (Scotland) Act 2014* also provides for aftercare services for young people leaving care to be provided support, defined as 'advice, guidance and assistance', including those who have been in secure care, up until their 26th birthday. The aim of throughcare and aftercare is to enable and support the young person to make a successful transition to independent adult living. The approach in secure care is therefore always to empower a young person to make decisions and take control of their lives and ensure they are in a position to achieve positive outcomes when they leave. It also involves ensuring that young people are at the heart of the assessment and planning process and fully involved in all aspects of their own throughcare and aftercare.[78]

2.4.3 Summary

An effective transition from secure care is critical to sustaining any positive outcomes achieved during secure care, to the continuity of care and enhanced care a child receives, and to reducing the risk of them re-entering secure care. Many of the barriers to children transitioning from secure care appear to lie with the broader OoHC system as it currently operates. These barriers include the lack of a dedicated child and adolescent mental health service for children in care, and an insufficient number of high needs placements – particularly in remote regions.

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[77] Kendrick, A., Walker, M., Barclay, A., Hunter, L., Malloch, M., Hill, M., & McIvor, G. (2008). The outcomes of secure care in Scotland. Scottish *Journal of Residential Child Care*, 7(1), 1-13.

[78] Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice.

The Statutory Review noted "the problems associated with children transitioning from secure care are not legislative. Effective transitioning from secure care relies upon the availability of suitable placements, and accessible services for addressing the complex needs of the children exiting from secure care."[79] Consultations undertaken for this evaluation confirm that there are significant challenges in finding appropriate placement options for children leaving secure care who continue to have complex needs and intensive support requirements.

A number of stakeholders suggested a need for a staged or step-down approach to transitioning children from secure care. They suggest this would assist in addressing the negative response many children experience in transitioning from the level of containment, routine and intensive staff attention, modelling and co-regulation they received at secure care to their next placement. The Statutory Review noted that Communities considered a step-down approach in the development of its new OoHC service system, including a model of complex care for high needs children. However, feedback on the Statutory Review highlighted concerns with the potential for such an approach to result in multiple care arrangements that may be against a child's best interests.

Many stakeholders spoke of the challenges in the OoHC system that have existed for some time. In its 2015 Discussion Paper on OoHC Reform Communities acknowledged many of these challenges. It stated that in the last ten years "there have been significant changes in the Western Australian community and the OOHC system, such as population growth and increasingly complex behaviour of children entering care. This has put pressure on the OOHC sector's ability to consistently deliver stable and healing care for these vulnerable children".[80]

Communities is working to develop and implement a number of reforms to respond to the pressures on the OoHC system. The Statutory Review notes that "the new service system will provide an increased number of complex care arrangements which are appropriately resourced to reduce the likelihood of readmissions to secure care and provide quality, effective community-based options". However, at the time this evaluation was conducted, many of these challenges remain and were repeatedly identified during the consultations as barriers to the effective transitioning of children from secure care.

The need for a multi-agency response for children with complex needs exiting secure care is a consistent theme. The interaction of relevant agencies would ideally occur within a set of agreed processes and commitments that facilitate multi-disciplinary teams and ensure access to resources and services required for an effective response to these children. While various attempts have been undertaken to establish collaboration between Communities and other agencies, consultations overwhelming suggest that more work needs to be done to develop a culture of shared decision making and responsibility between relevant government agencies and external organisations with regard to children in and transitioning out of secure care.

[79] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia, p.76

[80] http://www.dcp.wa.gov.au/ChildrenInCare/Pages/OOHCReform.aspx

2.4.4 Recommendations

Recommendation 8 - Additional high support placements be made available to facilitate a staged or "step-down" approach for some/selected young people exiting secure care.

Recommendation 9 - Establish an MOU between Communities and the Department of Education for access to the School of Special Educational Needs: Behaviour and Engagement (SSEN:BE) liaison and in-reach support.

The SSEN:BE liaison to continue for a short duration post-exit from secure care (e.g. for eight weeks post exit) as part of a "step down" process.

Recommendation 10 - Develop a transition protocol that includes a schedule of transition activities (providing details of placement and opportunities to view premises by video or photos,) for use by KFSCC staff. This protocol would include:

- early provision of information about the transition process and next placement (if known)
- ensuring the child's communication with a nominated staff member at the next placement (if known)
- an emphasis on all KFSCC staff discussing the different types of placement children may encounter (and ways that children might approach these various placements) if they have concerns.

2.5 What are the intended and/or unintended outcomes for children in care who have been admitted to the KFSCC?

- The experiences of children in a secure care arrangement, and the impact on their families and carers.
- Outcomes on exit from the KFSCC, and in the longer term.

2.5.1 Method

The following methods were utilised to identify intended and unintended outcomes for children admitted to the KFSCC, their families and carers.

- Document review: KFSCC Assessor Reports.
- Consultations with stakeholders including District staff.
- Correspondence with KFSCC Management.
- KFSCC staff surveys.
- Children's feedback forms completed on exit from secure care.
- Desktop review of relevant literature and published research.
- Case studies and interviews.

2.5.2 Findings

Examining outcomes for children admitted into secure care was challenged by the fact that reporting processes are not embedded or utilised by KFSCC in a systematic way. The February 2016 Assessor Report recommended that the KFSCC trial a Case Note template with the inclusion of assessment scales in addition to free narrative to establish more standardised means of recording children's outcomes during their secure care period. The Assessor Report noted that a more standardised approach would allow for "the improved measurement of outcomes, improved evaluation and increased efficiency". The June 2016 follow up Assessor Report noted the KFSCC had developed a "statistical process" to measure a child's behavioural and cognitive patterns whilst in care (involving nine categories). The Evaluation was provided with a copy of the daily self-rating scale template that has been introduced into KFSCC (date unknown) which children complete by nominating their response to a series of 11 questions about their day, interactions with staff, their anger levels, usefulness of self-care plans and feelings of safety.

The Evaluation was also provided with a template that KFSCC Secure Care Officers complete on children in their care during their shift. This document asks staff to utilise a scale to rate a child's status with regard to some Sanctuary based elements: Safety, Emotion Loss and Future. Staff rate a child's capacity to keep themselves safe, regulate their emotions, discuss their emotions, communicate regarding loss and their past, as well as their future aspirations and plans to remain safe when out of secure care. The Evaluation observed that the staff rating sheets appear to have been consistently completed from at least mid-2017, however there was no apparent collation of this data at the conclusion of the children's secure care arrangement. There was no summary of this data provided to the Evaluation, no evidence of a chart or table in the discharge summary, and no indication as to how the forms are entered in to the systems utilised by the centre. The Evaluation also did not identify any evidence of the outcomes arising from use of the Dr Tracy Westerman Aboriginal psychometric checklist that was said to be utilised with Aboriginal children at the KFSCC.

The 2018 Assessor Report noted that the Senior Clinical Psychologist at KFSCC indicated that the information from the staff assessment sheets was provided to progress meetings with the Districts.

The report also notes that the Senior Clinical Psychologist informed the Assessor that analysis of the data collected on each child while at secure care identified particular patterns of behaviour and that it was "intended that this data be used to help district's understand the patterns experienced by children who are at the service and how this can impact on the setting of achievable goals."[81] The Evaluation noted the daily rating sheets completed by staff have not gone through a process to develop a valid and reliably consistent scale that can be used confidently across all staff. This requires a number of staged steps (gathering and endorsement of content [e.g. S-E-L-F], item writing and revising, qualitative item feedback, psychometric evaluation, factor analysis, item spacing and scoring) in order to develop a robust instrument that has sufficient validity and reliability to aid evidence-based decision making.

2.5.2.1 Children's experiences of secure care

Consultations with District staff, external stakeholders, interviews with some young people who had a secure care admission and responses on feedback forms completed by 168 children in secure care highlight that for many children the safety, routine and access to one-on-one time with staff provided by secure care is a positive experience.

Feedback forms completed by children exiting secure care provide some insights into their experiences and their perceptions of its impact. It should be noted that the 2017 Assessor Report identified some concerns with the feedback forms at KFSCC. In particular the lack of a complaints/concerns section and that children are not explicitly informed their feedback is not anonymous. The Report suggested the need to provide additional opportunities for children to have their voices heard and to ensure they are aware the form is not anonymous and to have the child sign and date the form. The 2018 Assessor Report noted that the issue of children being informed the feedback form was not anonymous and the need for KFSCC Management to ensure staff made this clear to children as well as the purpose of the form remained an issue and recommended measures be taken to address this.

While there is some variation by age and number of admissions, the major themes arising from the interviews, feedback forms and, to a lesser extent, the file reviews are:

- The positive aspects of the child's experience revolve around feeling safe and nurtured while in KFSCC. The children in KFSCC, and those admitted some years previously, describe that they may have initially been scared and worried about being placed there but within a few days feel safe and secure. In terms of the "nurturing" they often refer to the availability of good food and reference individual staff who demonstrated understanding and sometimes made them feel "special" by allowing them extra privileges or spending time with them. A number mentioned that the time in the KFSCC allowed for them to get away from being pressured by others.
- The negative aspects, especially for the older children and those with multiple admissions, were around being "bored" and lack of activities to do that they were interested in or children of similar age to do them with, as well as having to go to bed and be treated like "little kids", not allowing them to do the things that other teenagers do - like phone friends, cook their own meals and do their own washing.
- The younger children were concerned about having to be alone and didn't like being apart from others at night, some mentioning how some staff would sit with them and

[81] Report for Department of Communities. Assessor Visit – Kath French Secure Care Centre. Independent Follow-Up Assessment Report. March 2018, p.21

help them get to sleep. They also mentioned the noise of some other children at night, banging doors and shouting, which scared them and made it hard to sleep.

Certainly, for many children it appears safety, routine and access to one-on-one time with staff override concerns about the restrictive nature of secure care. In thinking about their time in KFSCC one young person acknowledged in the interview that "once I calmed down, I felt comfortable there and it was alright"; another stated that "they were pretty well organised there and I always felt safe and supported." The feedback forms reflect that children's awareness of their containment is largely linked to being locked in their rooms and for some the lack of access to cigarettes, personal items such as mobile phones and engagement with social media. Comments about being locked in their rooms were largely raised in response to the question 'what was the worst part of secure care'.

Overall, the comments by children on the feedback forms do not suggest a dominant perception by children of their secure care arrangement as punitive nor an overriding sense of the deprivation of their liberty and rights. In response to the question 'what was the best part of Secure Care' many children identified the staff. Some comments were;

"spending time with staff"

"the way staff treated me"

"getting to know all the staff"

"sitting back talking to staff".

Similarly, in response to the question 'things that helped me to feel safe at Secure Care are': many children identified staff (n=76). Many also focused on the food, playing Xbox, the trampoline and having their own room as both the best part of secure care and things that helped them feel safe.

One of the questions in the feedback form asks what children feel they have learnt about themselves whilst at secure care. Responses to the question highlight a range of views among the children. Some responses were negative including those who wrote "*nothing*" or were critical of secure care's impact on them;

"Agitated and angry every day in here" [redacted]

"I don't like being locked up" [redacted]

"How much this place makes me loopy" [redacted]

Other responses reflect children's focus on some of their issues;

"That I'm a pot head" [redacted]

"I'm a stoner" [redacted]

"That I have a drinking problem, I'm an alcoholic" [redacted]

"That I need to control my anger" [redacted]

Another set of responses reflect evidence of a level of comprehension regarding particular activities and strategies that have obviously been discussed at the KFSCC:

"I've learnt that there are better ways to let out anger" [redacted]

"I can go without having a smoke for 5 weeks" [redacted]

"I learnt how to manage" [redacted] .

"That cutting and smoking and running away are not safe at all" [redacted]

"Learn my body is mine only and to keep myself safe' [redacted]

"I don't need self harm to be happy" [redacted]

"I have learnt to listen to others and have better self control" [redacted]

"To take care of myself" [redacted]

"That no-one should tell me who to be like" [redacted]

"How to be assertive, learn to be by myself' [redacted]

"To make better choices" [redacted]

"To never give up" [redacted]

There was also evidence of some children's more positive self-awareness:

"I am not a bad person" [redacted]

"Sometimes I'm too hard on myself" [redacted]

"I have learnt I can be patient' [redacted]

"That I'm good at school work" [redacted]

"That I am capable of positively dealing with my anger" [redacted]

"That I need to just take it easy and I'm smart" [redacted]

"That I have a bright future" [redacted]

"That I'm strong and awesome" [redacted]

Case Study: Derek* [redacted]

Derek* [redacted] He thought that he was sent to Kath French as "punishment" and remembers not knowing that he was being transferred there after his [redacted] but simply "being put in a DCP car and being told they were going for a drive". He thinks that was probably for the best as he admits he "would have kicked and screamed" if he knew where he was going. He didn't remember whether he was told about his rights or how he could appeal the decision to put him there but "it might have happened".

Derek recalls staying "at least a month or maybe two months" at Kath French. The records indicate it was 20 days, and that he settled in after a while and it was "okay being there". He considered that the time in secure care allowed him "to clear his head" and "think about things" after being in a "bad place". [redacted]

While at Kath French he remembered being treated well by the staff, and his records show that there were no critical incidents while he was there. He thought that he also learnt some ways of "coping with things" and fondly recalled a staff member who taught him how to play acoustic guitar – which he appreciated at the time and still plays. He also recalled that a number of the staff were kind and "good", and remembered the "food being good". There was nothing he thought that he would want to change about secure care and thought that it had "done him good".

* not his real name

Case Study: Eve, [redacted]

Eve* [redacted] She recalled the first time she was taken to secure care, she "knew nothing about it" and thought that "DCP don't have a right to lock up kids like that". She described the trip to the centre as "scary" and she recalled being "chucked in the car or van thingy and thought I was being kidnapped" and she was screaming and trying to run away. She remembers being "too upset to talk to anyone for days after arriving, and was distressed for "about a week".

She remembered staying "about three weeks [records show it was 20 days] and wanted to stay more as it was a safe place". She remembered being seen by a doctor or nurse the next day and "they got my permission to examine me" and "they told the rights stuff the first few times, but then I knew the stuff by heart".

She remembered that it was "all about safety" and they spent time "showing you could be safe".

When it was time to leave, she recalled being "scared to leave the first time, scared to go to a new place after only three weeks there and didn't have a placement to go to until the day before I left".

When asked about whether the times at secure had been helpful to her, she considered that they were generally "not helpful, being there I didn't have a chance to prove myself, it was because Districts weren't doing their jobs, the case manager exaggerated to get me there sometimes and I got too many restraints".

When asked about what she might change about secure care, she suggested "there is not much to do there but watch tv" and that "kids under 12 need longer there to get over the initial distress". In terms of the positive aspects of secure care, she noted that "the staff are really nice, get to know you and would stay up with you at night when you couldn't sleep, even though I think they weren't meant to, and they were not so strict at night and locking down sometimes".

When asked about whether overall secure care helped her, she stated that "don't think it works sometimes, a couple of times I would have been dead without going there but other times it wasn't helpful and it didn't change the way I was and left the same as I went in". When asked about what she would change she commented that there was "not enough time for kids to sort their head out" [redacted] and that in terms of how long to stay in secure care that you "need more time there when you really need it".

* Not her real name

2.5.2.2 *Intended outcomes*

Many of the intended outcomes of secure care include meeting the basic needs of children as well as working to address some of their dynamic risk factors amenable to deliberate and immediate intervention such as substance abuse, emotional dysregulation, impulsivity, violence and self-harming. Analysis of departmental documents and stakeholder consultations highlight a number of intended outcomes achieved for children in secure care. These include ensuring the child's immediate safety, a de-escalation of stress and anger, removal of the source of a range of risk behaviours and establishing routine.

An area of particular focus is to address any unmet needs in terms of the child's medical and general health needs. Secure care staff are described by KFSCC Management as assisting in meeting the daily needs of each child across all domains: physical, emotional, psychological, social, cultural and environmental. Staff surveys identify a range of outcomes that they perceive occurring for many children while at KFSCC. These include the child's basic needs being met through the provision of safety, shelter, planned meals, medical treatment, nurturing staff, privacy and their own room to develop healthy sleep routines. Children in secure care often present with a range of health needs that are addressed through the GP at the centre including updating immunisations, sexually transmitted infection testing, addressing skin and scabies infections, malnutrition, contraceptive advice and procedures, and drug and alcohol education. There is 24-hour medical coverage of the KFSCC by either the General Practitioner, or Nurse Practitioner or Nurse, who can be contacted either for advice, information, or to examine a child. All children are offered the opportunity for a medical examination within 24 to 48 hours of arrival at KFSCC. Children are also encouraged to make time to see medical staff daily. The ability of the service to manage specific health needs is restricted by limitations to attending external specialist appointments while admitted to secure care, however referrals and appointments can be arranged.

Other outcomes identified in KFSCC staff surveys can be seen as meeting some of the children's psychological needs through engaging in conversations with staff and having access to nonjudgmental adults who listen to their concerns, socialising with other children and staff, and having time to focus on themselves.

Comments within staff surveys reflect a diversity of views regarding the outcomes they observe in children at KFSCC:

> *"The space and time away from the pressures of peer groups, and external influences such as drugs, alcohol is very significant and allows the children time to relax, and begin to reflect. The medical attention and good nutrition is of huge benefit, and many children who have been resistant to medical intervention have been able to build a relationship and learn to see the value of medical professionals."*
>
> *"The children come into a safe place at Secure Care, they often come in distressed but regulate quickly."*
>
> *"A safe place for the kid to talk and to be able to be kids and play."*

Other staff identified the importance of secure care preventing children from continuing destructive behaviours. Comments included:

> *"Containment reduces access to harmful and mind affecting substances. It also offers respite from dangerous relationships and provides an opportunity to assist the children to reflect and develop a greater understanding of safety."*

"Environment provides safety to allow a break in cycles of harm, 'survival' responses."

"Opportunity to remove outside negative influences to allow the child time to focus on other aspects of their own safety and needs whilst their physical safety is no longer at risk."

2.5.2.3 Unintended outcomes

KFSCC staff surveys and consultations with District staff also highlight there can be some unintended outcomes arising from secure care. Some comments within the staff surveys highlighted some of the unintended outcomes of secure care.

"There are a small number of children - who view Secure Care as a punishment - and reject all attempts at engagement. Some children (very few) oppose the forced containment and deteriorate while they are here, this can result in damage to relationships with Case management and the Department as a whole."

"There is a cohort of children for whom the containment is so challenging that they are unable to relax and gain benefit."

"I can think of only a couple of children whose behaviours became increasingly worse and more unsafe each admission, in part I felt this was because they were being re-traumatised each time they came here."

Critical incidents

In relation to critical incidents, the Evaluation notes that section 6.3 (Critical Incidents) within the *Secure Care Practice Manual* provides particulars on the purpose, practice requirements, procedures and reporting/documentation.

The purpose of the procedure is to provide information and guidance to KFSCC personnel on keeping children and staff safe before, during and after a critical incident. The procedure identifies a critical incident that involves the following:

- An injury (or potential for injury which leads to staff having to utilise TCI physical intervention techniques).
- Any involuntary use of the Safe Room.
- Any incident where police or ambulance have been called to assist.
- Serious damage to property.

Analysis of the critical incident data provided to the Evaluation indicated no significant differences between gender, ATSI status or disability status. However, there was a trend in regard to age of first admission with both the youngest and the oldest having raised rates of critical incidents compared to those admitted who were aged 13 to 16 years. This was not statistically significant. In regard to the pattern of incidents during an admission, it was identified that critical incidents were more likely to occur within the first three to five days of admission, and within the two days prior to discharge. However, the data did not readily enable the identification of statistical patterns, nor detailed analysis of the nature of incidents.

A submission to the Statutory Review from a WA Legal Service raised concerns about an undue use of police at KFSCC resulting in criminal proceedings for children's behavioural issues while in secure care. The submission regarded this as punitive and excessive in many cases and going against the principles espoused by the centre. The Evaluation was informed that on very rare occasions critical incidents can escalate to the point where the Police are required to attend the KFSCC (however the Evaluation

was unable to identify how often this has occurred and note that calls to Police are rare, not encouraged and only occur when risk cannot be managed internally).

Aboriginal children

Another unintended, although unavoidable, outcome is the fact that for some Aboriginal children their admission to secure care and subsequent placement results in them being off country. Staff and stakeholders consulted spoke of their concerns about further heightening a child's sense of disconnection from kin, community, culture and the impact of this on their wellbeing. District staff consulted acknowledge that in their view Aboriginal children from remote regions did experience further trauma from the isolation and foreignness of their surroundings. This is an additional factor for referral in weighing up this impact versus the gain of a KFSCC admission. This situation also means that an unintended outcome is the challenge Communities faces in meeting the cultural safety needs of Aboriginal children while they are in secure care.

Exiting secure care

One of the unintended outcomes for some children exiting secure care is the adverse reaction they have to their placement following secure care. Consultations with stakeholders highlighted the stark contrast some children experience between the level of safety, routine and involvement of staff in secure care compared to their next placement. District staff described secure care as very removed from the reality children return to. Some stakeholders commented that for some children the return to heightened levels of stress and risk is immediately escalated due to the impact of leaving secure care and being triggered by their previous environment. This was apparently observed in some cases where children return to the situations they were removed from or to residential care homes.

The Evaluation is unable to make any significant comment on children's outcomes on exit from secure care over the medium to longer term. Certainly, the timing of some readmissions and the number of readmissions for some children would suggest evidence of placement breakdown and/or returns to extreme risk levels. It also suggests the challenges in effectively implementing children's care and safety planning, including accessing or engaging with the supports they require to sustain or continue to develop their stabilisation. District staff described some children's trajectory to and from secure care as a series of placement breakdowns and/or return to unsafe behaviours, including criminal behaviour that can even result in juvenile detention. A cohort of concern is those young children admitted to secure care. Of the 40 children who were initially admitted under 12 years of age, ten went on to be detained at Banksia Hill, with the range being from one detention entry to 13, and an average of five detention entries. This is slightly less than the older cohort with 35 per cent having an entry at Banksia Hill Detention Centre, and the range being from one to 14 entries to detention, and an average of three entries to detention (whilst in care).

Of the 16 secure care admissions from January to 30 April 2018, five had a different living arrangement following secure care, [redacted]

It is important to note that as the file reviews undertaken by the Evaluation are not a random sample (i.e. chosen because they were under 12 years on admission, multiple admissions etc.,) then they are not generalisable to the population of secure care admissions. There are themes that some children struggle to adjust to their new placement (e.g. complain about being with younger kids, or away from home areas) but others say that they are doing much better and have settled in well to their new placement (e.g., interview with [redacted]

2.5.3 Summary

Analysis of Communities records and the stakeholder consultations highlight a number of intended outcomes for children in secure care are being achieved. These include ensuring the child's immediate safety, a de-escalation of stress and anger, removal of the source of a range of risk behaviours and establishing routine. Many of the intended outcomes of secure care include meeting the basic needs of children as well as working to address some of their dynamic risk factors amenable to deliberate and immediate intervention such as substance abuse, emotional dysregulation, impulsivity, violence and self-harming. Other intended outcomes include the treatment of health issues, provision of nutritious meals, and awareness raising about safe and protective behaviours.

The Evaluation also noted some unintended outcomes related to being a long way from country and community for Aboriginal children, the impact of how some critical incidents are responded to and the impact of leaving secure care.

Existing data collection systems do not readily enable the identification of medium- or longer-term outcomes with regard to the impact of a secure care arrangement. One of the intentions of the Monitoring and Evaluation Framework designed by the Evaluation and described in Section 3, is to assist in the collection of data that will provide a means by which Communities can identify certain outcomes and have greater insights into the trajectory of the secure care cohort.

2.5.4 Recommendations

Recommendation 11 -	Communities to conduct yearly record audit of all secure care admissions based on a quality assurance and quality improvement framework.

2.6 Is the secure care model effective as a protective intervention for children?

- Examination of factors impacting children who have experienced multiple admissions to the KFSCC.

2.6.1 Method

To examine whether the secure care model is effective as a protective intervention the following sources of information were considered:

- Document review. – Including sample (11) relevant case file reviews from Objective and 51 approved extensions.
- Interviews with individuals who are currently placed in secure care or have previously been admitted to secure care.
- Extract from the ASSIST database provided by Communities for admissions.
- Case audits for those children with high (more than 5) and moderate (2 to 5) admissions to secure care during the period of 31 May 2011 – 30 April 2018.

2.6.2 Findings

The enabling legislation for secure care clearly states that the initial period in secure care must not exceed more than 21 days, which can be extended once for a further 21 days if warranted. The CCSA does not impose any limitations in regard to the time period between admissions. This contrasts with the *Mental Health Act 2014* which considers the period of involuntary status to be continuous if another involuntary order is made within seven days of the previous order ceasing, under section 388 (b).

Communities' initial background paper on a proposal for secure care in WA makes clear that a secure care admission was intended not as an alternative placement and is aimed at providing an "opportunity to assist the child or young person, to prevent a repeating pattern of high-risk behaviours and to establish proactive supports for their return to the community". [82]

Of the 219 children admitted to KFSCC between 31 May 2011 and 30 April 2018, nearly 60 per cent had only one admission. For those that had multiple admissions the majority, as shown in Table 2-5: Frequency of admissions below, had only two admissions.

Table 2-5: Frequency of admissions

Number of Admissions	Number of Children	Percentage	Cumulative Frequency
1	131	59.8%	59.8%
2	46	21.0%	80.8%
3	19	8.7%	89.5%
4	11	5.0%	94.5%
6	7	3.2%	97.7%
7	2	0.9%	98.6%
9	2	0.9%	99.5%
20	1	0.5%	100.0%
Total	**219**		

Looking at those with more than one admission, the gender mix is similar to that for all admissions, with slightly more children identified as ATSI (54.5%), and 27 per cent (n=24) identified as having a disability.

For those with multiple admissions, the age of first admission (Table 2-6 Age at first admission) is similar in distribution to the overall admissions.

[82] Department for Child Protection, (2011) Secure Care Background Paper, Effective date March 2011.

Table 2-6 Age at first admission

Age	Frequency	Percentage	Cumulative Percentage
7	1	1.1%	1.1%
9	1	1.1%	2.3%
10	7	8.0%	10.2%
11	7	8.0%	18.2%
12	12	13.6%	31.8%
13	26	29.5%	61.4%
14	15	17.0%	78.4%
15	13	14.8%	93.2%
16	6	6.8%	100.0%
Total	**88**	**100.0%**	

Comparing those with multiple admissions and those with a single admission, there were no significant differences in the number of entries to Banksia Hill Detention Centre following admission to KFSCC (p= .175), the age of first admission (p=.433) and while there was an increased likelihood of more "critical incidents in Secure Care" (p=.070) this was in keeping with the longer periods in secure care overall.

2.6.2.1 Extensions and readmissions

Of the 418 admissions considered by the Evaluation, 100 were extended, representing approximately 24 per cent of admissions. As noted, the average gap between admissions, for those admitted more than once, is 153 days, however 36 readmissions were within ten days of discharge and of those 14 were readmitted within two days of discharge. [redacted].

The intention of the CCSA, and the Department's policy, is that placement in secure care be for a short duration and only in 'exceptional circumstances' if that duration is extended. Currently the CCSA and Department Policy, do not provide guidance on the readmission of children after discharge, and the Evaluation identified a need for the current policy to be amended to reflect the wording of the CCSA regarding "exceptional reasons for doing so".

The current policy[84] states:

> *Further admissions should not occur except in circumstances where there are new risks of the child causing significant harm to him/herself or another person or the risk of causing significant harm has not reduced.*

[83] An unplanned exit as the child was discharged to detention

[84] Policy on Children Entering Secure Care, accessed from dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/

A review of a sample of cases where there were multiple admissions indicated that the referrals for readmission made only mention of previous admissions (e.g. date of admission and number are listed, and at most, a brief comment such as 'for absconding') In addition, referrals for readmission do not specifically address the Policy regarding the need for there to be a *"new risks of the child causing significant harm to him/herself or another person"* or *"the risk of causing significant harm has not reduced"*.

Analysis of applications for extensions indicates a lack of clear and consistent understanding as to what constitutes "exceptional reasons" as grounds for extension as discussed in Section 2.2.2.2 (Page 26).

[redacted]

The Evaluation notes that in cases with a high number of admissions the involvement of senior officials from external agencies tended to occur only after a number of repeated admissions in a relatively short period and that cases of multiple admissions within a relatively short time period probably warranted a high level response given that such children were not substantially benefiting from admission to secure care.

2.6.3 Summary

The secure care model was designed to be a purely protective intervention. Stakeholders consulted suggest that many children, especially younger children, do not appear to perceive secure care as punitive once they have been at the centre. There is a degree of consensus among those in the Districts that secure care is "invaluable" to a cohort of children who are at extreme risk. "It keeps kids safe" was a common statement from those consulted.

To determine whether secure care operates as an effective protective intervention for children in WA requires consideration not only of the immediate and short-term impact of secure care in keeping children safe from harm to themselves and others, but also with respect to the medium and long-term impact of being detained for a period of time in an unfamiliar and isolated environment. From the interviews with past and current children placed at Kath French, and from analysis of the feedback forms and file reviews, it is clear that for most children, admission provides for a cessation of their risk behaviours – with only a few continuing to self-harm or assault others once admitted. However, for approximately 5 per cent of children the period in secure care does not appear to disrupt their

trajectory and they continue to engage in behaviours that place themselves and others at risk and they go onto multiple admissions over a number of years.

2.6.4 Recommendations

Recommendation 12 -	A policy be developed that provides for an escalation of a case to be reviewed at the Executive Director level in Communities (and an option of referral to a coordinated multi-agency review) if a child has more than three secure care admissions in a 12-month period.

Recommendation 13 -	Policy and supporting forms, be developed to facilitate consistency and further clarifying particulars of content in applications for extensions.

Recommendation 14 -	The current referral form be modified to include a summary of risks identified as the basis for any previous admissions to secure care.

2.7 Are there alternative options for managing the behaviour of children who are under 12 years of age?

2.7.1 Method

The following methods were used to examine alternative options for managing the behaviour of children under 12 years of age:

- Document review: *Review of the Kath French Secure Care Centre – Under 12 Year old Cohort*, *Casework Practice Manual*, KFSCC Assessor Reports, *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre*.
- KFSCC staff surveys.
- Interviews with individuals who are currently placed in secure care or have previously been admitted to secure care.
- Extract from the ASSIST database provided by Communities for admissions between May 2011 and April 2018
- Case file reviews from the *Objective* database, for those children admitted under the age of 12 years.
- Environmental scan of available services.

2.7.2 Findings

2.7.2.1 Legislative provisions

Secure care

The CCSA places no restriction on the age of children who can be admitted to KFSCC. While the Victorian model focussing on children aged over ten years was mentioned during the debate of the Amendment Bill, neither the Second Reading Speech nor Explanatory Memorandum makes mention

of this age restriction. The intended age limits were however, referred to in the debate. The Hon Alison Xamon said: "I note that the Bill will establish a nine-bed secure-care facility for children aged 12 years and older..."[85]. The first admission of a child under 12 years of age to secure care occurred in March 2013, almost two years after the KFSCC opened.

Forensic placements

In WA, the *Criminal Code Act Compilation Act 1913* (s29) recognises three age ranges in regard to criminal responsibility: for children under ten years, there is no criminal responsibility; from 10 to less than 14 years there is the presumption against criminal responsibility; and under 18 years at the time of committing the offence, the individual is treated as a juvenile and is dealt with through *Young Offenders Act 1994* (s 3) for most offences. Therefore, very few children under 12 years of age would receive custodial sentences.

2.7.2.2 Mental health services

There is currently a bilateral schedule between Communities and Child and Adolescent Health Service (CAHS) which manage the metropolitan CAMHS. The schedule prioritises children in care in terms of access to community clinics. This arrangement allows for earlier appointments and waitlist prioritisation. However, the schedule does not specifically provide for children in secure care.

CAMHS provides mental health programs to children and young people up to the age of 17. This includes services in the community and in a hospital setting. Children and families are referred to these services by their treating therapist, specialist, GP, school or other community organisation. Information and advice about accessing a mental health program is available by contacting a local community clinic.

2.7.2.3 Alternative services

Child and Adolescent Mental Health Services in WA are the public mental health service for persons up to 18 years of age, however some specific services are designed for specific age groups (e.g. primary aged children, adolescents, youth). These services have undergone significant restructuring over the past twenty years with a significant reduction in the availability of medium to long stay inpatient facilities, with the closure of Hillview Terrace Adolescent Hospital and Stubbs Terrace Children's Unit, and the closure of day programs in the children's hospital and in the community clinics. More recently, the delayed closure of Princess Margaret Hospital was partially responsible for a reduction in acute inpatient beds for children and increased demand for young adolescent beds at Bentley Hospital (now the East Metropolitan Youth Unit and a service for people aged 16 to 24 years who present with complex and acute mental health issues). A review of the currently available public mental health services for children and young adolescents is provided below.

Inpatient services

<u>Ward 5A Perth Children's Hospital</u>

The Mental Health Inpatient Unit on Ward 5A at Perth Children's Hospital is the state-wide assessment and treatment facility for children and young people up to 16 years old with complex and acute mental health issues. Ward 5A is a recovery focused patient and family centred service. It offers a seven-day

[85] Western Australia, Parliamentary Debates, Legislative Council, 16 November 2010, The Hon Alison Xamon. p8761.

multidisciplinary program in a safe environment for voluntary and involuntary patients as authorised under the *Mental Health Act 2014*.

The unit offers short term assessment, brief intervention and therapeutic group programs, depending on a child's needs. It works closely with agencies in the community, from the time a child is admitted until they are discharged, to ensure their care is consistent and can be maintained when they return home.

Ward 5A has a total of 20 beds and is divided into two sections:

- A 14-bed acute section for children and adolescents who require a higher level of assessment, monitoring and treatment.
- A low-acuity section with 6 beds for those who require less support and supervision during their treatment and recovery.

The service is staffed by mental health professionals including nurses, psychiatrists, psychologists, occupational therapists, social workers, an Aboriginal Liaison Officer and education staff.

Specialised programs

Touchstone

Touchstone is a structured day service for young people aged 12-17 years and their families. The multi-disciplinary team comprises a consultant child and adolescent psychiatrist, service manager, and an experienced therapy team of nurses, psychologists, social workers, occupational, art and creative therapists.

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. Young people can be referred by their community CAMHS teams for assessment as to whether the program might be of benefit to them. Young people attend for at least three days of the week, with on-site school sessions as part of the program.

Pathways

Pathways is an evidence-based Tier 4 service providing intensive therapeutic day services in addition to educational support to children with complex social, behavioural, mental health and developmental issues. Pathways is suitable for children aged 0-12.

The service operates Monday to Friday supporting families from metropolitan Perth as well as rural and remote areas of WA. The team consists of a broad range of mental health clinicians with training and experience in nursing, social work, psychiatry, occupational therapy, clinical psychology, speech pathology, teaching, art and play therapy, and administration services.

Referrals to Pathways are considered from:

- CAHS Mental Health
- Child Development Centres
- Mental Health and or private health practitioners
- Department of Communities
- School of Special Educational Needs - Behaviour and Engagement.

Multisystemic Therapy

Mental Health Multisystemic Therapy is a community-based program for at-risk young people aged 12 to 16 years. The mental health professionals (mainly clinical psychologists, social workers and mental health nurses) work in the young person's home, with a young person's parents and caregivers, their school and other groups concerned about the child's behaviour. The goal is to help families develop the skills needed to manage their challenges so that the young person has a brighter, healthier future.

Community Clinics (Metropolitan)

There are ten community CAMHS services across the Perth metropolitan area. These provide assessment and treatment of persistent mental health difficulties in infants, children and young people. Children and families are referred to these services by their treating therapist, specialist, GP, school or other community organisation.

- Clarkson CAMHS
- Hillarys CAMHS
- Warwick CAMHS
- Swan CAMHS
- Shenton CAMHS
- Armadale CAMHS
- Bentley Family Clinic
- Fremantle CAMHS
- Peel CAMHS
- Rockingham CAMHS

Country Child and Adolescent Mental Health Services

The WA Country Health Service delivers mental health services to regional Western Australia from seven health regions: Kimberley, Pilbara, Midwest, Wheatbelt, Goldfields, South West and Great Southern. The constitution of the clinics varies but teams consist of multi-disciplinary professionals including mental health nurses, clinical psychologists, psychologists, psychiatrists, social workers, occupational therapists, Aboriginal mental health workers and youth counsellors.

2.7.2.4 Admissions of children under 12 years of age and mental health concerns

Communities thematic review of the under 12 years old cohort at KFSCC, along with consultations with District staff conducted for this evaluation, highlight a difference in how other agencies and services perceive the complex needs of younger children in care. This was especially evident in relation to younger children's mental health services where the assessment of a child's needs and risk, especially to themselves, was often not aligned with the views of staff in the Districts.

In 2011, the Commissioner for Children and Young People WA identified an absence of understanding about the mental health and wellbeing needs of young children, and a significant under-resourcing of mental health programs and services for this cohort. This resulted in poor access for children requiring help, especially for those living in regional and remote areas of the State where there are often no appropriate services.[86] Similarly, in the 2015 follow up report, the Commissioner identified ongoing shortfalls in appropriate specialist services for children with severe mental health needs, particularly those with complex needs. The report notes "there remains a reluctance to acknowledge that very

[86] Commissioner for Children and Young People WA 2011, Report of the Inquiry into the mental health and wellbeing of children and young people in WA, WA, Perth.

young children can and do experience mental health issues that may manifest as serious social, emotional or behavioural problems (for example, aggression, anxiety and depression)."[87]

The Department's thematic review of the under 12 years old admissions to secure care noted that many within this cohort have significant mental health conditions and, prior to their admission to secure care, had accessed a range of psychological services to varying degrees. Some 45 per cent had been involved with CAMHS (referred to or serviced by) though there were no further details noted in their secure care referral forms. Engagement with these services were characterised by the review as deficient in understanding the context of the children's lives. The thematic review also notes that a number of children had been prematurely discharged from CAMHS, for reasons that work against the context of this cohort (instability, chaotic, unable to engage in standard therapeutic approaches) and that "CAMHS service lacks the persistence and flexibility needed to work with this group of clients."[88] Despite demonstrating significant need for mental health services, the review states these children are being dismissed as having 'behavioural issues' and therefore not requiring the services of CAMHS. The review suggests that the admission of younger children to secure care was in part due to other relevant services not meeting their needs effectively. The review indicates there are cases of children under 12 years of age admitted to KFSCC, who require, but are without, a mental health professional's indication of their level of risk.

A submission to the Statutory Review detailed a case study of a child under 12 years of age [redacted] While the child's extreme risk met the admission criteria for secure care, there was no other service model available to meet their complex mental health needs.

The Evaluation has previously noted a lack of consistent and mandated individual advocacy for children.[89] For pre-adolescent children, the ability to advocate on their own behalf will be viewed as limited. In this regard, it is noted that the Advocate for Children in Care exists to support children and young people "to have a voice" in decisions that affect them and in services provided to them by Communities. Furthermore, the Advocate will support children and young people to have a decision, such as secure care placement, reviewed. The Advocate is engaged on request by the child or someone acting on their behalf. The Evaluation sees benefit in formalising the involvement of the Advocate for assisting this younger cohort of children under 12 years of age (and those with significant intellectual disability) admitted to secure care.

An analysis of 17 referrals for admission of children under 12 years to KFSCC in the past two years prior to the commencement of the Evaluation indicated that concerns over mental health issues was present in the vast majority of referrals and concerns over substance use were also present in most referrals (See Figure 2-10 and also section 2.2).

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[87] Commissioner for Children and Young People WA 2015, Our Children Can't Wait – Review of the implementation of recommendations of the 2011 Report of the Inquiry into the mental health and wellbeing of children and young people in WA, WA, Perth. p.4

[88] Department of Communities. Review of the Kath French Secure Care Centre – under 12 year old cohort. 2018. Perth, Western Australia.p.7

[89] Commissioner for Children and Young People WA 2017, Oversight of services for children and young people in Western Australia, Commissioner for Children and Young People WA, Perth

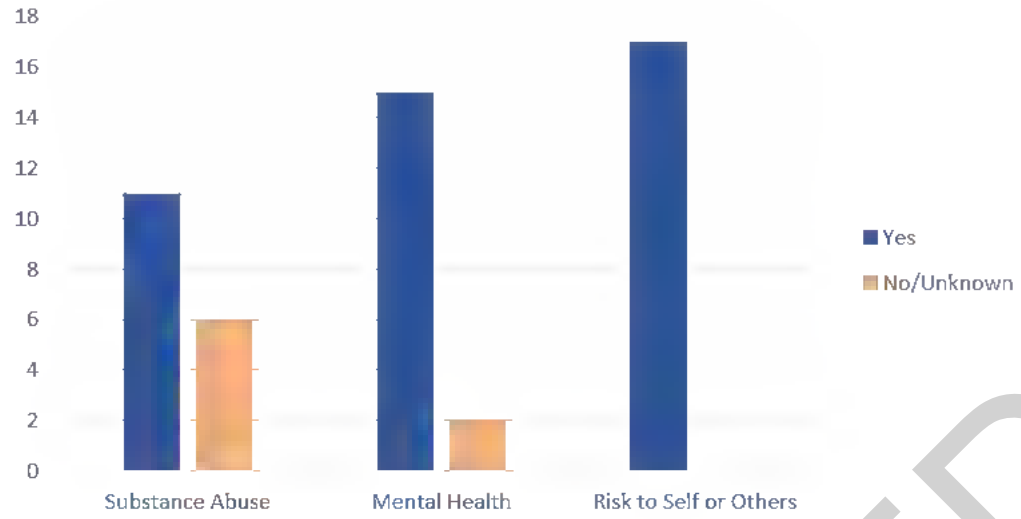

Figure 2-10: Concerns of individuals aged under 12 years over mental health, substance abuse and risk to self or others

All the referrals indicated significant risk to self or others and determined that the risk was immediate and substantial, as required by the Act and policy.

Over half the referrals considered that the level of chronicity of the concerns was "extremely high", despite their relatively young age. Over 90 per cent were considered to have extremely high intensity and frequency of risk concerns. Of the 16 admissions from January –April 2018, five admissions (31%) were children under 12 years of age and two were children aged 12.

2.7.3 Summary

There is an absence of service models available to meet the complex mental health needs of young children in care. While there are some alternative mental health services for children in WA these are not easily accessed by children in care with complex needs, many of whom require a purpose designed service. Access to private mental health services under the Australian Government's *Better Access to Mental Health Care Initiative* has improved, however, these are focused on mild to moderate mental health conditions managed through primary and secondary health providers. The scheme has improved the rate of treatment for adults with mood disorders and, to a lesser extent, children and adolescents however there appears to be little impact on severely disturbed younger people.[90]

The WA MHC[91] long term plan published in 2015, encouragingly includes the statement that:

> *Due to a critical need to improve services for children in care, we will aim to establish a specialised Children in Care program as a matter of urgency.*[92]

[90] Pirkis, J. & Ftanou, M. (2011). Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation.

[91] Western Australian Mental Health Commission (2015). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission

[92] Western Australian Mental Health Commission (2015). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission. p.81

Unfortunately, the "Key Achievements 2015-2017"[93] document published in 2018 fails to make any mention of the initiative, however the 'Plan update'[94] may provide details of the planning for the service. While it is planned to see people up until 18 years of age, except in the case of cognitive impairments where an extension to the age limit would be considered, the current documents make no mention of any lower age limit. It would be important that the service be inclusive of younger children.

Case file reviews identified children under 12 years of age have been admitted to KFSCC who require, but are without, a mental health professional's indication of their mental health status and needs.

2.7.4 Recommendations

Recommendation 15 - The Bilateral Schedule between Communities and Child and Adolescent Health Service (CAHS) be renegotiated to provide and promote timely health services for children admitted to KFSCC.

Recommendation 16 - Update the *Policy on Children Entering Secure Care* to include that unless extenuating circumstances exist, children under 12 years of age (who currently meet the admission criteria) should be admitted to a high support/needs placement rather than secure care - if in the best interests of the child.

In instances where:

- a child under 12 years of age or
- a child with significant intellectual disability

is admitted into secure care, that the Advocate for Children in Care is to make contact with the child within 48 hours of admission.

A review of the current secure care materials and procedures (e.g. admission materials, their rights and procedures necessary for review etc.) be undertaken so as to guide the modification, or development of supplementary materials, for younger children and those with learning difficulties.

[93] https://www.mhc.wa.gov.au/media/2132/mhc17-36542-key-achievements-september-2017.pdf

[94] Was due to be released in 2018 but was not available at the time of the Evaluation.

2.8 Is the physical environment fit for purpose to manage operational performance requirements?

- Review of the physical environment and its ability to manage risk (to children themselves, other children and staff) and provide a safe and therapeutic environment.

2.8.1 Method

The following approach was adopted to assess whether the KFSCC facility was fit for purpose to manage operational performance requirements:

- A site inspection of the KFSCC facility.
- Discussion with KFSCC Management.
- KFSCC staff surveys.
- Input from the Head of Service of a secure care facility (Good Shepherd Centre) based in Scotland – following a site visit to the KFSCC.
- A site visit to the Secure Welfare Services facilities:
  - Maribyrnong Unit for girls and
  - Ascot Vale Unit for boys (both located in Victoria).

2.8.2 Findings

2.8.2.1 Overview

The KFSCC is a stand-alone facility located in Stoneville, approximately 40km from Perth CBD.

In 1999, the Kath French Centre was opened to offer assessment and planning for vulnerable and troubled young people. The building was reconfigured to a secure facility and commenced operations as the Kath French Secure Care Centre in May 2011.

The infrastructure from which the KFSCC operates consists of the following facilities:

- Each child has their own ensuite bedroom. These are spacious, clean and comfortable.
- Two small living areas with a television (TV) unit, sofa and large beanbag in each. The living areas are sparse with basic furnishings.
- Two fully equipped kitchens and two dining areas with a table and chairs.
- A small laundry.
- Two Activity Rooms. These areas are used by Secure Care and Education Officers to deliver psycho-educational activities and arts & crafts.
- A well-equipped medical room, management / administration offices and staffing area situated at the front of the building. Video conference equipment is located in a meeting room within the management / administration section of the facility.
- A 'Safe Room' is allocated at the back of the building. This is an unfurnished, bare floored, lockable room used to isolate children who are in crisis and whose behaviour has become unmanageable. This room is used voluntarily and involuntarily for children who are unsafe and cannot be safely managed in a less restrictive manner.
- Two outdoor areas each surrounded by high security fences. These each have a basketball area (with reasonable sized grassed areas and gardens around the edges and look out over the surrounding bush), table tennis, barbeque and a trampoline.

Facility standards or guidelines

When considering the matter "Is the physical environment fit for purpose", it is acknowledged that there are no specific standards for secure care infrastructure/facilities. It is noted, however, that Guidelines[95] exist for the planning and design of other facilities that have some nexus to secure care, being Child and Adolescent Mental Health Units. Whilst not directly comparable, the design environment has some similarities to that of secure care.

These Guidelines identify that a unit (for acute mentally ill young people) must create an environment for young people that, inter alia:

- enables the safe and efficient operation in order to optimise outcomes
- provides a comfortable welcoming environment with domestic furnishings, decor and artwork
- provides quiet spaces and active indoor and outdoor spaces for therapy, relaxation, activities and education
- maximises natural light and, where possible, views
- avoids isolated spaces for both consumer and staff safety (e.g. unsupervised blind spots, recessed areas, alcoves)
- provides space and dedicated equipment (e.g. sensory modulation) as a means of reducing the potential for aggressive behaviour
- provides security that is as unobtrusive as possible
- provides culturally sensitive services for Aboriginal and Torres Strait Islanders, Maori and Pacific Islanders, and other culturally and linguistically diverse young people.[96]

Further, the Guidelines provide useful commentary on the general layout of the facility/unit:

> *"The environment should be conducive to the management of complex behaviours offering the capacity for observation of young people by staff and security to minimise and manage disturbed behaviours in the least restrictive environment. However, this should be achieved with a therapeutic focus so that while necessary measures for safety and security are in place, they are non-intrusive and do not convey a custodial environment."*[97]

Operational considerations – staff feedback

In assessing the physical environment of the KFSCC in light of the above Guidelines, the Evaluation has taken into account the views of staff of the KFSCC. In this regard, a survey of KFSCC staff was undertaken so as to obtain their views on key elements of the KFSCC operating model and infrastructure. A total of 20 responses were received.

The survey posed the question "Thinking about the Kath French building, is its layout/configuration appropriate". The following responses were received

[95] Australasian Health Facility Guidelines, Part B - Health Facility Briefing and Planning 0132 - Child and Adolescent Mental Health Unit, Revision 7.0 21 December 2016

[96] Ibid, Section 01.04 Description of Unit.

[97] Ibid, Section 01.04, Page 5

Response	Count	Percentage
Yes	2	10%
Mostly	11	55%
No	7	35%

Of the 20 responses, nearly two-thirds (65%) considered the KFSCC layout/configuration mostly appropriate and approximately 35% considered that the layout/configuration was not appropriate.

To better understand the supporting reasons that underpin staff responses, the following key comments are shown reflecting key themes.

Comment	Frequency
Positives – Building layout/configuration	
The Pod is in the centre of the building so can see the children on both North and South if they are in the lounges.	2
Ability to separate and bring together children safely. Communication between staff possible across the building with "duress" phones	1
Negatives – Building layout/configuration	
The rooms are too small. The layout is such that it is hard to move children, staff, other professionals and tradespersons thorough the building safely, and without impacting on activities. There is no appropriate meeting space, for family and District visits, psych appointments. There is not enough office space	7
Layout results in an environment which is very controlled and formal - children have limited areas to relax and play with very limited areas they can use to de-escalate. Moving between areas is difficult and the building is very impersonal	3
When we are trying to manage 5-6 children with high needs and major behavioural concerns, the building is simply too small. Often this results in other children being witness to incidents and/ or being triggered by the noise. Access to the pod (our office) means entering through one of the lounge rooms and if children are escalated in both lounge rooms then it can be tricky to leave or enter the pod. The doors are loud which often triggers the children.	3
The building itself limits staff ability to create therapeutic environment	2

In addition to the comments included in the table above, a selection of KFSCC staff feedback that elaborate on the above themes is provided below:

Staff A

There are very few positives about the building. The doors and windows are not robust enough. The bedrooms are too big and create emptiness and a reflection of loss. The video conferencing occurs in what is arguably the most unsafe are of the building, which can limit children's access to meetings due to risk assessment.

Staff B

The areas are all walk through areas - making it difficult to prevent disruptive access from other staff or children. The bedroom areas are held in a hallway on either side of the building

and the door entry is extremely noisy - making it difficult to maintain calm and a sense of safety for the children. Temperature control is an issue - the AC zones are not clearly defined and create extremes in temperature.

Staff C

The positive aspects are our ability to manage the environment to ensure the safety of the children. For example, TV's in cabinets, Velcro curtains, roller shutters in kitchens.

Staff D

The building is safe and secure to support the needs of children, however, not designed to provide enough outside space for children's outdoor activities... The building lacks the capacity to meet the needs of all children, specifically, when there are six children admitted in the Centre who require individualised personal space to meet there needs or who cannot be mixed with other children due to their behavioural issues. Sometimes unsettled children's constant banging on doors including yelling and screaming disrupts or unsettles other children because of lack of sound proof within the building. This does extend to night times as well....

Staff E

Negatives - Moving the children around from north to south, using the foyer can be difficult as some refuse to move from there and cause a restraint to happen if they become unsafe and try to damage the door. The use of the safe room if a child is occupied in the East area, limited rooms in the building to isolate the children if there is an escalation.

Adverse incidents

Proxy indicators taken into account when assessing the appropriateness of the KFSCC physical environment and its ability to manage risk (to children themselves, other children and staff[98]), is the frequency of:

- children absconding from the facility
- the incidence of harm whilst a child is admitted into secure care.

From a review of limited available data on the above, the number of incidents where a child has absconded from secure care is low. Similarly, the number of incidents of physical harm occurring to a child whilst in the KFSCC is also relatively low.

In this regard, the facility generally meets a fundamental requirement of keeping a child in a physically secure and safe environment.

Other factors

Other factors identified were the physical distance of the KFSCC from CBD Perth (approx. 40 kms). Views received by the Evaluation were that the current location of the KFSCC creates challenges in readily accessing specialist health professional staff (who might be able to visit the KFSCC to provide services) and also access to relevant specialist outreach services within KFSCC.

The Evaluation conducted a site visit to the Secure Welfare Service facilities operating in Victoria – Maribyrnong Unit (girls) and the Ascot Vale Unit (boys). Both are located approximately 8 km

[98] Staff carry walkie talkies, with non-positional duress alarm included and the facility is covered by CCTV.

north-west of Melbourne CBD. In general terms, both of the Victorian facilities are materially similar in configuration to that of the KFSCC facility, however, two key differences between the Victorian and WA facilities are:

- A dedicated Admissions Room is accessed by a purpose-built/specific entrance door to the facility (Victoria), whereas the current building layout of KFSCC usually requires one side of the external area to be cleared as the transport (van) enters the facility's perimeter, and a lounge area is also generally required to be cleared during an admissions process.
- The Victorian SWS facilities have a better layout to enable movement of staff, and access by staff to various sections of the building separate to that of the young people admitted to the facility.

2.8.3 Summary

The KFSCC facility is generally configured to meet the requirements of a secure facility with appropriate physical barriers and electronic monitoring. However, specific design shortcomings include:

- Lack of a separate entry and "Admissions Room" (accessed via a purpose built/specific entrance door to the facility).
- The video conference equipment is housed within a meeting room within the management and administration section. Accordingly, use of video conferencing requires children to access the relevant room via the working/office area of management and administration personnel. This represents a risk.
- The layout of the KFSCC building has limited common passage access and results in access to bedrooms, the kitchen and education rooms via the lounge areas – creates challenges during critical incidents including restraints and transfer to safe room.
- Limited provision of floor space/room configuration to enable older children to participate in independent, age appropriate, life skill activities.
- General internal finishes and furnishings are not reflective of contemporary guidelines in secure facilities (e.g. comfortable welcoming environment with domestic furnishings, décor and artwork and a dedicated area/room (with sensory modulation fit out) as a means of reducing the potential for aggressive behaviour) etc.

2.8.4 Recommendations

Recommendation 17 - Communities consider as a priority the reconfiguration/establishment of:

i. a dedicated admissions entrance and triage room for children being admitted in the facility and

ii. a meeting room from which video conferencing can occur without the child having to access the relevant room via the working/office area of KFSCC Management and administration area.

2.9 Is there sufficient oversight in place?

This section gives consideration to the:

- Role and qualifications of assessors
- Management of assessors and follow-up in relation to recommendations or required actions identified in reports following visits.
- Recommendations to strengthen the oversight and governance of the facility.

2.9.1 Method

To examine whether there is sufficient oversight with regard to secure care the following were considered:

- *Children and Community Services Act 2004.*
- *Report of the Statutory Review of the Children and Community Services Act 2004.*
- Assessor Reports of the KFSCC Submissions to the Statutory Review of the Children and Community Services Act 2004.
- Consultations with external stakeholders.

2.9.2 Findings

2.9.2.1 Role and qualifications of assessors

In WA, Assessors were part of the initial suite of secure care provisions provided for in the amendments to the CCSA that came into effect in 2011. The role of Assessors was to provide oversight of secure care facilities and residential facilities (as defined in the CCSA). As described in the CCSA, section 125A (3), 'An assessor may, at any time, visit a facility and do one or more of the following:

(a) Enter and inspect the facility
(b) Inquire into the operation and management of the facility
(c) Inquire into the wellbeing of any child in the facility
(d) See and talk with any child in the facility
(e) Inspect any document relating to the facility or to any child in the facility'.

The *Information about the Independent Assessment Process of Residential Facilities* outlines that the assessment process for the secure care facility and residential facilities consists of two stages, the first being a comprehensive assessment and review of residential facilities as described in the Act and outlined above. The second stage involves the assessment and review of the implementation of the recommendations generated from the initial visit and report. An Assessor must provide a written report to Director General, Communities about each visit.

The report format is to include:

- Assessment Scope: The scope of the assessment is negotiated and planned before the visit with the relevant residential facility, Residential Care/CEO of Service, and for country Residential Group Homes – the relevant District Office. While the primary focus of the visit is described in the scope document, assessors have the discretion to look into any matter they consider appropriate consistent with functions (a) to (e) as described above.
- Summary of Observations and Recommendations.

Stage 1: Initial Assessment Visit

1. The Assessor is engaged by Director General, Communities to visit a nominated residential facility (Communities provided or funded).
2. The required contact information for the facility, names of residents and relevant Child Protection Worker's names are provided to the Assessor.
3. The Assessor will make contact with the nominated residential facility and relevant stakeholders as required and make the necessary logistical arrangements and to gather information.
4. Final Report Initial Visit – the report is provided to the residential facility and peer assessor to check and correct details of fact, to provide additional relevant information about special conditions or circumstances before the report is finalised. The final report is provided to Director General, Communities. Copies of the report are forwarded to the Service.

Stage 2: Follow-Up Assessment Visit

- Three months after completion of Initial Visit Final Report the designated Follow-Up Visit Assessor will visit the residential facility to determine if the recommendations have been completed.
- A template for the report will be provided with a table, complete with information taken from the initial assessment report which is to be reviewed.
- The Follow-up Assessor is engaged by Director General, Communities to visit the nominated residential facility (Department provided or funded).
- The updated contact information for the facility, names of residents and relevant Child Protection Worker's names are provided to the Follow Up Assessor.
- The Assessor will make contact with the nominated residential facility and relevant stakeholders as required and make the necessary logistical arrangements and to gather information.
- Final Report Follow Up Visit – the report is provided to the residential facility and peer assessor to check and correct details of fact, to provide additional relevant information about special conditions or circumstances before the report is finalised.

The final report is provided to Communities' Director General and to KFSCC. Under an MOU between Communities and the Commissioner for Children and Young People (CCYP), the CCYP receives a redacted version (children's names removed) of all Assessor reports (both for KFSCC and residential facilities). The Ombudsman Office of WA determines if and when they will visit and has visited KFSCC to promote its complaints process.

Assessors are recruited through Communities' tendering process and appointed by the CEO. No specific qualifications are required. The specific selection criteria for Assessors at KFSCC includes knowledge, understanding and experience of:

- contemporary residential and therapeutic care models and current issues facing OoHC in WA
- interviewing, engaging and obtaining information from children and young people
- utilising culturally appropriate strategies to engage Aboriginal people
- engaging people from culturally and linguistically diverse backgrounds.

2.9.2.2 *Management of assessors and follow-up in relation to recommendations or required actions identified in reports following visits.*

For administrative purposes, Assessors are coordinated by the Manager Standards Monitoring Unit located within the Regulation and Quality Unit of the Commissioning and Sector Engagement Division of Communities.

Consultations with relevant stakeholders, including children in care advocates, highlight concerns that the Assessor process lacks accountability – in particular, the selection and management of Assessors by the department responsible for secure care. In addition, there are concerns regarding the process for follow-up regarding matters identified during an assessment and how it is determined that these issues are completed/resolved satisfactorily. Some of those consulted also suggested that there is a lack of a strategic and consistent approach regarding the terms of reference/focus of the Assessor – including that there are no Standards or monitoring framework to assess secure care against. The current option for Assessors to be able to "have the discretion to look into any matter they consider appropriate" has resulted in a range of issues detailed in the various Assessor reports yet without any consistency meaning these issues are not tracked over time. It has also resulted in reports that appear ad hoc and lack a method for comparison over the longer term.

The Assessors were not established as child advocates; their intended role, as provided in section 125A of the CCSA, is to provide systems oversight. There were concerns expressed to the Evaluation team that the assessment process thus does not adequately nor systematically incorporate the rights and views of children and young people with regard to secure care. There were also concerns that children in secure care and their family/carers may not always be aware that they have the right to request the person in charge of the facility to arrange for an Assessor to visit the facility and see and talk with the child. The CCYP submission to the Statutory Review noted that to their knowledge no children and/or their family/carers had requested a visit.

The Evaluation was informed that the Assessor's schedule is dynamic and amended for a variety of reasons (increased priority of other residential facility, Assessor availability, other reviews such as Sanctuary certification etc.). Hence there has been no fixed schedule for the use of Assessors at KFSCC. Between 2011 and 2013 there was one visit per year. In late 2014 there was some amendment to the Assessor process that impacted on the way visits are scheduled. The change involved an initial Assessor visit and a follow up visit to determine if KFSCC has implemented the recommendation of the initial report. The visits and follow up visits often occur within a financial year (e.g. 2014/15, 2015/16, 2017/18). Usually the follow up visit occurs 3-4 months after the initial visit and can take up to a couple of months for the report to be finalised. Currently the scheduling of Assessor visits to KFSCC occur within the scheduling of the residential facilities.

The Statutory Review considered the operation and effectiveness of the Assessor provisions in some detail. It noted the distinction between systems oversight of the secure care facility, and oversight of the processes and procedures governing individual secure care arrangements. Submissions to the Statutory Review emphasised the need for heightened independent oversight of the secure care facility. The Statutory Review concluded that the "locked nature of the facility requires a higher degree of independent oversight than the current section 125A model allows" and should be assigned to an entity "completely independent of the Department." Furthermore, that oversight should be informed by Aboriginal people with knowledge of the particular cultural security and safety needs of Aboriginal

children in secure care.[99] The Evaluation supports this finding and associated Recommendation 23 from the Statutory Review.

2.9.3 Summary

Oversight of the KFSCC, including the Assessor process, requires processes that provide for greater accountability and community confidence. Recommendations by this evaluation for enhancing current procedures and policy documents regarding the operations of secure care are intended to provide mechanisms for increased departmental oversight of secure care admissions, extensions and the decision making processes of KFSCC Management.

The Evaluation noted that there is currently very little publicly available information about the operations of the KFSCC. The annual report, which is intended to provide public information on the KFSCC's performance, provides data on the average cost per day and some general comments only. There is no detail about occupancy rates, number of admissions, length of stay etc. Greater emphasis on public accountability would work to ensure confidence in the operations of the KFSCC and the accountability of Communities. There is also a need to ensure recognition is accorded to children's rights and experiences whilst in secure care, and greater emphasis should be placed on a means by which children's views can be incorporated into assessment processes including those who have exited secure care. The Evaluation has developed and applied a set of interview questions for consulting with children both during and post a secure care admission, and these could continue to be applied with children and provide for a consistent means of accessing children's input as well as providing for quality improvement/assurance processes.

2.9.4 Recommendations

Recommendation 18 -	That the assessment of KFSCC be conducted in accordance with a comprehensive monitoring/standards framework. The Evaluation notes and supports Recommendation 23 of the Statutory Review that suggested assessment be undertaken by an independent body with sufficient broad oversight powers, involve a minimum number of annual visits including unannounced visits and include Aboriginal people to assess and determine whether the specific needs of Aboriginal children in secure care are being met.

Recommendation 19 -	That a protocol be formalised for the forwarding of the Assessor Reports to an external body such as CCYP/Ombudsman - for review.

[99] Department of Communities, Statutory Review of the Children and Community Services Act 2004. Perth, Western Australia, p.79-80.

2.10 Can resources be allocated more efficiently to address service gaps in the system?

This section explores:

- The interface between Communities and other Government and non-Government agencies that support children and young people in care; including hospitals, mental health and juvenile justice services.
- The availability of, and entry criteria to, other facilities in WA that provide intensive support for children who may pose a risk to themselves or others, to determine alternative placement pathways.
- The impact that the current model of whole of community response has on secure care admissions.

2.10.1Method

The following were utilised to identify service gaps and the allocation of resources across government to meet the needs of, and improve outcomes for, children with complex needs.

- Document review: *Children and Community Services Act (2004)*, Second Reading Speech, *Policy on Children Entering Secure Care*, KFSCC Tip Sheet, *Statutory Review on Children and Community Services Act (2004), Review of the Kath French Secure Care Centre – Under 12 Year old Cohort, Casework Practice Manual*, KFSCC Assessor Reports, *2012 Evaluation of Child Protection Workers Experience: Kath French Secure Care Centre*, Rapid Response Framework.
- Consultations with stakeholders including District staff.
- Correspondence with KFSCC Management.
- KFSCC staff surveys.
- Desktop review of relevant literature and published research.

2.10.2Findings

2.10.2.1 Interface between government and non-government agencies that support children and young people in care

Consultations with some Communities staff identified a number of service gaps for children in OoHC, especially those with complex needs. Many of these were regarded as associated with the need for more collaboration and coordination between Communities and other relevant government agencies, and responsibility from other agencies towards children in care. There is a consensus among many working in the Districts and other areas of Communities that a collaborative interagency response is critical to managing and reducing the risks many children in care present to themselves and/or others. Barriers to collaboration identified by Communities staff and external stakeholders include the perception of responsibility towards the child because the child is in OoHC. Other barriers include resource issues including limited and differing allocation of resources and how these impact on capacity for collaborative practice and a lack of incentive or requirement for other agencies to work with Communities. Consultations with Communities staff reveal a perception of other agencies as inflexible and not responsive to children in care, thereby adding to the burden of caseworkers and the Districts. The Evaluation also observed gaps in knowledge and particular attitudes among different agencies towards each other's practices, care models and responsibilities.

The importance and effectiveness of relationships with other agencies was identified by staff from regional Districts who regard the way they engage with some other agencies as working better than those in the metropolitan areas. This was attributed to local circumstances where everybody knows each other and they have to rely on each other in the absence of a lot of other supports. One stakeholder commented that formalised agreements possess the potential to strengthen partnerships between agencies, but in their experience, success very much comes down to the capacity and dedication of individuals involved. Other stakeholders spoke of the example of the YPECN program and the ability of a dedicated coordinator to "cut through red tape" and bring senior level agency representatives together. This was highlighted as having the potential to be an effective process if it continued to be supported or extended to some of the children exiting secure care.

Department of Education

One of the major gaps the Evaluation identified was providing for the education of children with complex needs, including facilitating children's re-engagement with education after secure care. This issue was repeatedly raised in consultations with District staff. Concerns were expressed about the educational status of children in secure care and the number of barriers they face in re-engaging with education after secure care. Where possible, KFSCC Education Officers contact schools or District Education Officers to ascertain enrolment status and reports from previous attendance. The Evaluation was informed that future enrolment information is often not possible due to lack of knowledge of where the child will reside after exit from secure care. This means that many children exit secure care without a current/relevant Documented Education Plan and caseworkers will often have had no contact with Department of Education staff.

The consensus among those consulted is that children with extremely complex needs who come out of secure care have been disengaged from a formal education system for some time, and face enormous challenges with re-engaging into any system. There are few schools with facilities to accommodate children who struggle with regulation and the class room environment. There is also a lack of alternative pathways for children until they reach the age of 15 which, for many children, is too late because of the extent of the disengagement that has taken place for many years.

Some District staff described the discrimination children in care generally experience in some schools and the ways in which children in care with high needs and trauma can be shamed, disrespected and made to feel very uncomfortable at school. In some Districts senior school staff were described as working in direct contrast to the trauma-informed practices of the OoHC sector that was regarded as triggering children's anger, stress and antisocial behaviour and resulted in children being suspended. Some District staff described an attitude among Department of Education staff that, because Communities are the legal guardians, then educational and engagement issues of children are their responsibility. They spoke of processes and systems that are utilised to reengage children that are not extended to OoHC children, especially those in residential homes.

District staff consulted did acknowledge that issues with education staff can be school specific. An example was provided of a child in one area of a district who was at 30 per cent attendance with no assistance from the school's participation team or other staff despite the requests from Communities staff. This was consistent with comments from the Education Department representative who acknowledged that there was no current protocol, or dedicated staff, to liaise with secure care in regard to current admissions, while there is a protocol and assigned staff for school-aged children admitted to Banksia Hill. The child was moved to a high needs transitional housing placement in another area. The placement provider, along with an external support organisation and school staff, worked at reengaging the child and actively maintaining his engagement on a daily basis. They developed relationships with the child, acted immediately if he was absent and his attendance is now

at 85 per cent. The staff member identified that this level of intensive support was required for each child coming from secure care and others with extremely complex needs and required all stakeholders to be involved in planning.

There is limited available research regarding education and child protection system collaboration in Australia. Gill et al (2018) found that although the Rapid Response Framework entitles all children and young people in WA in OoHC to priority access to education, knowledge of this was limited including among Communities stakeholders they interviewed[100]. Two participants expressed that they were unaware that students in OoHC were entitled to priority service access. An Education Officer explained in a study of agency workers' perceptions of cross-system collaboration to support students in out-of-home care; "It's a good plan, but it needs more dissemination to different departments to say that children in care are priority cases".[101] There are some studies available that demonstrate the way that strengthening cross-system communication between agencies can improve service delivery. For example, in Queensland, employing a social worker to work collaboratively across the education, child protection and juvenile justice systems led to an increased capacity among educators to support 'at risk' students and families.[102] Similarly, regular communication between caseworkers and educators, and well-implemented supports, enabled improved outcomes among Queensland students in OoHC.[103] Also in Queensland, Ziviani et al (2013) explored stakeholders' perceptions of cross-system collaboration to support students in OoHC with complex needs and highlighted the benefits of multi-disciplinary agency coordination of services.[104] This research demonstrated that a mandated agreement for shared responsibility and service integration between the education, health and child protection services minimised gaps in service provision through coordinated planning.

Mental Health Commission

There was a consensus across those working in the OoHC sector regarding the difficulty of accessing mental health services for children in care with extremely complex needs. Many of those consulted identified a gap in the availability of specialist services and professionals who can provide quality assessments and treatment for children in care. A common complaint was that accessing child and adolescent mental health services is very challenging and that if assessments do occur, they can often result in an outcome whereby difficulties being experienced by a child are deemed 'behavioural' rather than an indication of existing or emerging mental health concerns and therefore not warranting of a service.

There was a widespread perception among those consulted that services are working at cross purposes with regard to the conception of many children's risks and needs. Many Communities staff and other stakeholders involved with children in OoHC spoke of the difficulties of getting children

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[100] The Rapid Response Framework (2011) was a Cabinet endorsed across-government framework to help address the specific and complex health, psychological, housing, educational and employment needs of children and young people in care. It was designed to provide priority access to services and thereby be a mechanism for achieving positive outcomes for these children and young people. It included provision for priority access to government services, collaborative case management, care planning and review processes that are inclusive of the views of carers, children and young people and their families, professionals and service providers. It also sought to provide information sharing practices to support joint assessment and planning and quality and timely psychological, developmental, health and educational assessments.

[101] Gill, A. & Oakley, G. (2018). Agency workers' perceptions of cross-system collaboration to support students in out-of-home care. Children Australia.

[102] Knight, B. A., Knight, C., & Teghe, D. (2007). Students at risk: Interagency collaboration in Queensland. Youth Studies Australia, 26 (2), 50–57.

[103] Tilbury, C. (2010). Educational status of children and young people in care. Children Australia, 35 (4), 7–13.

[104] Ziviani, J., Darlington, Y., Feeney, R., Meredith, P., & Head, B. (2013). Children with disabilities in out-of-home care: Perspectives on organizational collaborations. *Children and Youth Services Review*, 35 (5), 797–805

accepted into a CAMHS service and the challenges that the CAMHS clinical model poses to accommodating children with complex needs and in care. CAMHS emphasis on the need for children to be stable, for carers to be actively involved, and for children to maintain regularity in their appointments results in many children in care with complex needs never getting the support they require. Consultations with stakeholders identified that access to an inpatient mental health facility for children in care is very limited. These facilities were also criticised for their reticence to keep children who are admitted for any length of time, and the failure to work with District staff before a child is discharged and arrangements can be made to assist and support them.

One Clinical Psychologist with Communities observed:

> *"Most agencies gate keep to an enormous extent. Health is almost impossible (in my view) to bring on board for the behavioural issues our children present with. Issues of attachment dysregulation and trauma. These issues are perhaps as dangerous to life as the classical diagnoses that lend to more mainstream and medical (drug) therapies."*

This observation has been noted elsewhere. A discussion paper on children and young people's vulnerability by the CCYP (2018), notes that many services are currently unable to provide the intensive therapeutic, relationship-based care required to meet the complex needs of vulnerable children. It suggests that many services are not designed to address underlying causes of vulnerability (such as trauma and family dysfunction), particularly if their scope is limited to dealing with the child's presenting issues and that this can reduce the impact and effectiveness of interventions provided.[105]

The Evaluation was informed that the MHC *WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025* identifies the need to increase community support and treatment of specialised state-wide services through the commissioning of a children in care program. In 2014, MHC commenced some preliminary work to identify the needs and costs for a specialised service for children in care with complex needs. However, this work was not progressed to a finalised business case. The MHC continues to work towards meeting the actions in the Plan, however it is not currently prioritising the finalisation and submission of this specific business case at this stage.

Department of Justice

Consultations highlight that Communities staff experience challenges in engaging with children in care detained at Banksia Hill Detention Centre. Some District Directors spoke of caseworkers being unable to access any information about children while in detention and staff at Banksia Hill Detention Centre were described as "really difficult" to work with. These views were also expressed by District education staff with regard to information required for coordinating children's education reengagement after detention. Consultations with Department of Justice representatives highlighted challenges to the flow of information specifically with regard to children coming to Banksia Hill Detention Centre from KFSCC and vice versa, with staff in both organisations described as working in silos. It was proposed to the Evaluation team that on transfer of a young person from KFSCC, a summary document be provided to Banksia Hill Detention Centre containing the following:

- assessment of risks (identified) at time of admission and whether they have altered/changed at time of discharge

[105] Commissioner for Children and Young People 2018, "It's like a big circle trap": Discussion paper on children and young people's vulnerability, Commissioner for Children and Young People WA, Perth. p.25

- particulars of treatment applied during time in secure care (including medical and psychological assessments and ongoing treatment requirements/recommendations
- particulars of risk factors and triggers applicable to the young person.

The Evaluation notes that there are provisions within the CCSA which enable the exchange of information between agencies. In particular, section 23 of the CCSA enables the CEO of Communities to disclose relevant information to a public authority... a corresponding authority, a non-government provider or an interested person and to request relevant information from those bodies or persons. Section 24A of the CCSA also enables the CEO of Communities to obtain copies of certain reports from the Department of Justice (formerly Department of Corrective Services), which is required to be provided to Communities upon request.

2.10.2.2 Availability of, and entry criteria to, other facilities in WA that provide intensive support for children

Many of those consulted for the Evaluation described a lack of services able to meet the intensive needs of children in care and especially those under 12 years of age and those who are 17 years old. These cohorts are described as falling between the gaps because of the way services are designed around a certain age criterion. One external stakeholder described a common perception among services that 17 year olds are too difficult to deal with or will turn 18 and not be eligible for the service so would avoid engaging with them. There are some limited outreach services in the metropolitan region such as Youth Link and Youth Reach South for children and young people aged 14-21 years.

Communities funds and delivers a range of services to at-risk youth, primarily in the tertiary or crisis-end of the youth service spectrum. Consultations with relevant areas in Communities highlighted that agency service agreements have little focus on young people at extreme risk. The proportion of this cohort actually receiving services is also low. Service providers in the youth at risk services sector also report barriers to adequately meeting the needs of this cohort due to the complexity of needs, the intensity of supports required and the lack of local specialist services.

Other services for children in care/leaving care with complex needs are:

- Specialised Foster Care.
- Disability and Placement Support.
- Residential care.
- The Transitional High Needs Program.
- Psychology Services and psychiatry supports (Peel District).
- Young People with Exceptionally Complex Needs Mentoring.
- Young People with Exceptionally Complex Needs.
- Leaving Care Services – District and funded.
- Living Independently for the First Time pilot.

There are a number of highly fragmented and geographically scattered services external to Communities that are often highly targeted to one programmatic area. Multiple government agencies also fund at risk youth programs suggesting a need for effective agency collaboration.

Communities is currently developing a new Action Plan for At-Risk Youth under a broader *State Youth Strategy* and consulted widely with the sector during 2018 as part of this process.

Consultation with advocates for children in care highlighted that older children often dislike residential group homes and advocates' stress the importance of young people having far more say in the planning around their placements. They also identified this group as continuing to have extremely

complex and high needs but with far less access to supports and age appropriate services, especially mental health services. District staff consulted for this evaluation described a cohort of older children who are very difficult to manage and who are disengaged from any service and choose to 'self-place', coming and going from the residential houses they are assigned to. They admitted that for many of these older children all they can really do is implement some harm and risk minimisation strategies and attempt to stay engaged with them or be aware of their location. One District Director admitted that even the most experienced staff can struggle with older teenagers in care with complex needs because they are generally so resistant to any support and many are very "streetwise". These young people have difficulty in accessing public[106] or private housing because of their age and homeless services can be a risky environment because they cater to adults, although there are some specific youth homelessness services. In the regions and remote areas there are very few if any services or options for these young people.

In Perth, there is the At Risk Youth Accommodation service that provides support for a small group of older teenagers in care who require placement and choose to not engage with services. The At Risk Youth Accommodation service provides overnight accommodation, an evening meal and breakfast, and laundry facilities, and the opportunity for young people to contact their case workers or other supports. The service was described by one stakeholder as working well for this cohort but the youth have to be out of the facility by 10am and are often left with nowhere to go. They suggested the need for a daytime support option where children and youth who are disengaged can access more wrap-around services and support.

Alternative placements

Most of those consulted in the Districts regarded the resourcing of secure care as appropriate and necessary acknowledging that secure care is a very high cost resource, in part due to the high staff to child ratios which some stakeholders argue is excessive. Stakeholders commented on the need to better resource high needs placements and the capacity of residential homes to provide more intensive services. This was regarded as one way of increasing the options available for children exiting secure care as well as children in care with complex needs.

In terms of alternatives to secure care – especially for children who cannot be admitted (no bed available for instance), District staff spoke of using what they can – and the fact that they are familiar with having to work in this way. They described utilising mental health services where possible, emergency departments, and residential care facilities with assistance from police when children abscond. One District Clinical Psychologist (Communities) stated, with regard to alternatives:

> *"I have to say there NEVER have been any alternatives and there are NONE now."*

There was a consensus among those consulted for this evaluation regarding the need for more alternative placement options for children with extremely complex needs, especially those that can provide long term intensive and supported care arrangements. These placements are regarded as one of the best means of potentially preventing some children from escalating to the point of needing secure care. Consultations highlighted concerns with how non-government placement services are currently contracted and funded, and the limitations this presents to the availability of suitable options for children exiting secure care and having a better chance of remaining out of secure care. One District Director suggested that the lack of placement options for children with extremely complex

[106] The Evaluation has been advised of a protocol with the State housing authority (Communities) for children in care. Further, the Rapid Response Framework prioritises access to services for children in care, including those in secure care.

needs reflects the need for reform in the whole OoHC system. They felt that the current contract funding of non-government providers worked against sustaining their commitment to children with extremely complex needs. They noted these issues were identified through Communities OoHC review process and believed it was critical that reforms were implemented. The Director suggested that reforms to the provision and contracting of services would create better flow-through and more sustainable contracting. This was described as potentially building better and greater capacity in the organisations Communities contracts, especially high needs placement options.

The Evaluation was informed that current funding arrangements mean OoHC placement services are unable to offer staff long-term contracts and attract high quality staff suitable for working more intensively with high needs children. The current system of short-term contracts for an individual child was identified by several in the sector as working against sustainable outcomes for children because the funding is removed if the placement breaks down (essentially it is a break to the contract). This approach also works against high needs placements taking on children exiting secure care because of the high risk they pose to a contract not being fulfilled, as well as the high level of resourcing they require. The consensus among many consulted was that the system requires a sustainable model so that agencies are funded upfront and can provide for better quality of carers and supports that work to ensure the child remains in the placement, stabilises and avoids any readmissions to secure care.

The Intensive Support Service (ISS) in New South Wales provides an interesting model of an intensive case management approach to children with complex needs and a potential mechanism for directing children away from a secure care arrangement at Sherwood House. The ISS was developed in response to the high costs the NSW DFaCS was incurring for 1:1 placements for children, and the increasing demand for such placements which was deemed financially unsustainable. ISS caseworkers have their case management load capped at 6 because of the comprehensive and intensive nature of the service that supports the child on a daily basis and ensure their needs are met by connecting them to other agencies, education and vocational pathways, clinical services, counselling, and life skills development. Caseworkers also take direct responsibility for engaging with a child's family including assisting and support family mediation and linking family to support services. There is also a high level of reporting and monitoring of each case and departmental oversight of the ISS cases. ISS teams are located in different areas across the state. Caseworkers develop specific skill sets as well as receive specific training to undertake the ISS role. The model is designed to respond to the complexity of the work involved in responding to the needs of this cohort of children particularly linking across government agencies and non-government service providers.

2.10.2.3 Impact that the current model of whole of community response has on secure care admissions

The *Policy on Children Entering Secure Care* acknowledges Communities has the legislative mandate to provide secure care, but notes that "*all relevant government and community sector organisations have a shared responsibility to support the child when in secure care and contribute to ongoing service provision after the child leaves secure care*". It highlights the requirements of other government agencies to prioritise access to services for children in the CEO's care including those in secure care in accordance with the Rapid Response Framework.

Overwhelmingly, the view from those consulted is that the Rapid Response Framework is "not working" and education, mental health and disability services are "not at the table." District staff talked of staff in other agencies with no awareness of the Framework including, in one District, the Lead Clinical Psychologist in the Department of Education. One District Director suggested that Rapid Response is "essentially non-existent" because responding to children in care is viewed by other agencies as a sole Communities responsibility. The Statutory Review identified that the across-

government Rapid Response Framework and MOUs with agencies were designed to enhance integrated service delivery. Yet it also notes the anecdotal evidence that suggests "child protection workers experience continuing difficulties accessing services for children in care under Rapid Response".

Outside of the Rapid Response Framework there is currently little in place that formalises a coordinated whole of community response to children in care with complex needs and at extreme levels of risk.

The Evaluation notes the reforms being pursued as a result of the *Out-of-Home Care Strategic Directions in Western Australia 2015-2020*. Communities have indicated an Outcomes Framework has been developed and baseline report published in 2016[107] for Children in OoHC. This outcomes framework focuses on increasing the accountability of the entire out-of-home care sector on the outcomes achieved for children in out-of-home care. As a dual benefit, the information received through this process will steer continuous improvement in the broader out-of-home care system. Informed by the outcomes framework, Communities indicate they will intensify its work with government partners to commit to and implement the Rapid Response Framework[108]. The *Response to Out-of-Home Care Strategic Directions in Western Australia 2015-2020 Discussion Paper* adds;

> *The Government recognises that the current, largely internal regulatory oversight raises perceptions of a lack of rigour and conflicts-of-interest. The Government is committed to addressing this and will seek to increase external oversight of the out-of-home care system. This may take the form of an external accreditation system.*
>
> *To complement this work, the Department has worked with the community services sector to review and update the Better Care, Better Services Framework[109], with a central focus of further aligning the standards framework with the National Standards for Out-of-Home Care (p.4).*

2.10.3 Summary

MOUs, bi-lateral agreements and the Rapid Response Framework have all intended to improve multiagency case work and respond effectively to children with extremely complex needs. Despite this, the Evaluation noted a lack of a multi-agency response toward individual children in care and especially those with complex needs including those in secure care. Effective communication and collaboration between Communities and other agencies is critical to responding to children with complex needs and improving children's outcomes post secure care. To achieve this requires changes in how these 'partner agencies' perceive their responsibility to children in care and value the importance of providing a continuum of care. In this regard, the Evaluation supports recommendation 47 of the Statutory Review that specified the need to prioritise the provision of all necessary government services to children transitioning out of secure care in order to reduce the potential for readmission.

[107] https://www.dcp.wa.gov.au/ChildrenInCare/Documents/Outcomes%20Framework%20for%20Children%20in%20OOHC%20in%20WA%202015-16%20Baseline%20Indicator.pdf

[108] Department for Child Protection and Family Support (2015). *Response to Out-of-Home Care Strategic Directions in Western Australia 2015-2020 Discussion Paper*, Retrieved from https://www.dcp.wa.gov.au/ChildrenInCare/Documents/Response%20to%20Out-of-Home%20Care%20Discussion%20Paper.pdf

[109] https://www.dcp.wa.gov.au/ChildrenInCare/Pages/Better%20care%20better%20services%202017%20November.pdf

There is an apparent urgent demand for more high needs placements to ensure such services are available to all children in care who require them both before and after secure care. There is also an apparent urgent need to introduce proposed reforms to funding these intensive placements so they have capacity and expertise to accommodate this cohort of children, deliver the support they require to prevent a breakdown in placement, and facilitate their reengagement into the community and, especially, their education.

2.10.4Recommendations

Recommendation 20 -	The Evaluation supports the implementation Recommendation 47 of the Statutory Review – s22 of the Act be amended to require a public authority prescribed in regulations to prioritise and provide services in certain circumstances.

Recommendation 21 -	Communities convey to Mental Health Commission / Department of Health the importance of prioritising the development of a specialised children in care mental health program as outlined in the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*.

Recommendation 22 -	That a protocol/MOU be established between Communities and Department of Justice that formalises and specifies the relevant information to be exchanged between the parties so as to assist in the effective transition of relevant youth between KFSCC and Banksia Hill Detention Centre (and vice versa).

3 Monitoring and Evaluation Framework

3.1 Introduction

The Monitoring and Evaluation Framework (M&E Framework) is designed to establish the structure by which to measure and monitor the activities of the KFSCC and assist Communities to track particular outcomes for children admitted to secure care. It has been designed as a flexible framework intended to establish an evidence base and enhance the planning, implementing, and reporting of the secure care model. The M&E Framework defines the aims, key indicators, type of data to be collected, data sources and reporting methods.

From an overall perspective, the M&E Framework takes into consideration that secure care exists within a continuum of care for children and that the KFSCC is a part of the broader OoHC system that seeks to serve the needs and wellbeing of children in care.

In particular, the aims of the M&E Framework are to support:

- The provision of evidence of the impact of secure care during and post admission.
- Understanding of the relationships between the secure care model and the broader OoHC system in which it operates.
- Improved planning and decision-making by identifying the most effective aspects of secure care and the barriers to its intended aims.
- Creation of a secure care evidence base which can continue to be developed as part of the on-going management and refinement of secure care and the care provided to children with extremely complex needs.
- A common direction across Communities about what is required to ensure secure care is operating as intended.
- Accountability of, and confidence in the secure care model.

The M&E Framework operates alongside the KFSCC *Service Improvement Plan* that includes mechanisms that allow for gathering staff views that feed directly into service improvement processes and which is documented and utilised for annual status reporting by KFSCC Management. This is commented on further towards the end of this section.

The M&E Framework should be cognisant of the resultant oversight model arising from Recommendation 23 of the *Statutory Review* and in particular findings arising from assessor visits (or equivalent) under the revised model. This data will supplement the information and reporting associated with the M&E framework. Findings (and associated recommendations) arising from this process will also contribute to action items included within the KFSCC *Service Improvement Plan*.

3.2 Program logic

The Evaluation has developed a Program Logic for the KFSCC. It identifies the key elements of the secure care model and provides an overview of how the model operates, as well as the outcomes or results that the service is intended to produce. The Program Logic provides a useful reference point from which to design an M&E Framework.

The Outcomes of the KFSCC model are classified into immediate (at point of exit from the KFSCC) and longer-term outcomes for which the KFSCC can make some contribution. It is acknowledged, however, that the longer-term outcomes are subject to a variety of factors/variables external to the KFSCC model and outside of the centre's control.

The M&E Framework has been developed with an acknowledgement that Communities has control over their inputs and activities, influence over the immediate-term outcomes and an interest in the longer-term outcomes. This differentiation is illustrated in Figure 3-1 below. In many cases, M&E Frameworks will focus on actions in the areas of control and influence. The M&E Framework described below asks Communities to look beyond their sphere of influence and to consider the contribution being made towards achieving longer-term outcomes, recognising that others will have a role in achieving outcomes over the longer-term.

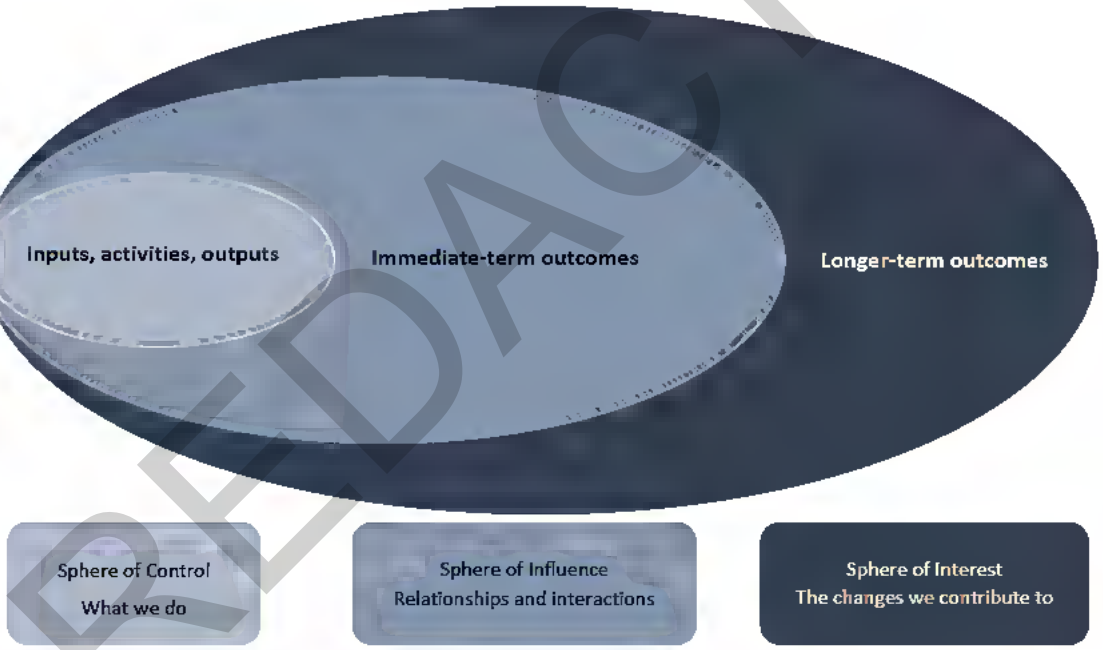
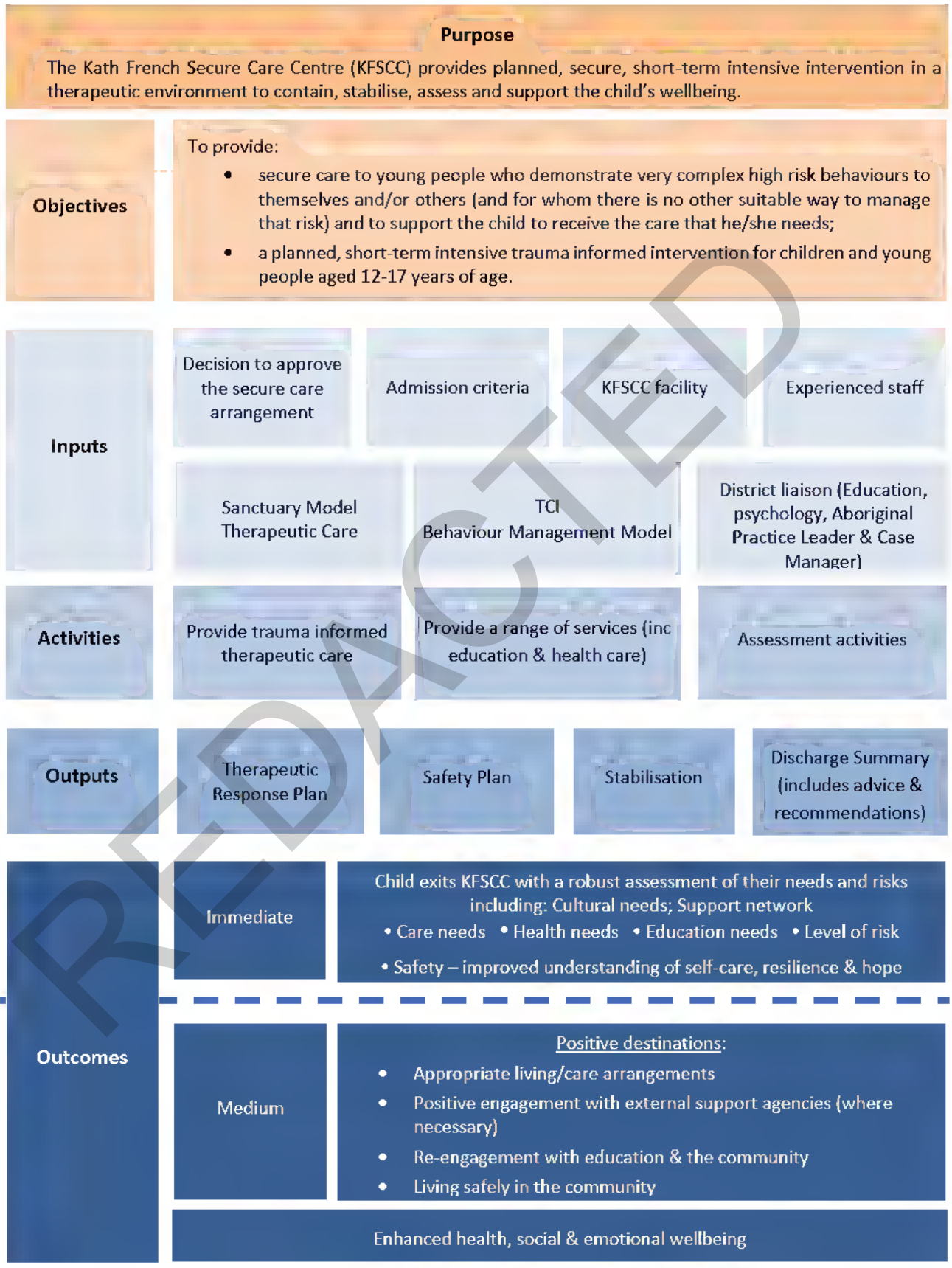


Figure 3-1: Spheres of control, influence and interest

Figure 3-2 identifies the linkage of the components of the KFSCC program logic model on the following page.

Figure 3-2: KFSCC program logic model



3.3 The M&E framework

The M&E Framework aims to provide Communities with a level of oversight on the delivery of secure care together with the establishment of a data collection framework to assist in assessing the impact/outcomes of the KFSCC and the secure care model. The data collection and reporting process comprises of:

i. Operational data (e.g. occupancy rates, pending referrals etc.) that focuses on short to medium term KFSCC activity

ii. Outcome data (e.g. stabilisation in problematic behaviour etc.) that focuses on establishing an evidence-base regarding the impact of secure care during admission and also post exit from secure care and short term follow-up.

The above is further described in the following section.

3.3.1 Operations – outputs

The first level of the M&E Framework is focused on how KFSCC operates at a system level by identifying key performance indicators that relate to the current and daily operational activities of the KFSCC. These indicators can be seen as 'iceberg indicators' in that they reflect larger areas of interest and allow for staff and management to detect and respond in a timely way. This involves data collection and reporting that provides management of the KFSCC with a mechanism for collating current activity data that can be utilised to identify and address current operational issues and provides Communities with enhanced oversight of the operations of the KFSCC. It also establishes a form of "clinical governance" and embeds a quality assurance approach that allows for evidence-based decision making and empirical evaluation of quality improvement initiatives and projects.

The reporting format consists of a "dashboard" type system with indicators showing current rates of KPIs relative to averages. The frequency of reporting (and type of data provided to Communities) are detailed below.

3.3.1.1 *Operational Governance Schedule*

Frequency	Activity Data
Daily	Incidents, restraints and use of Safe Room in past 24 hours compared to annual average
	Measurable case notes outcomes for past 24 hours
Weekly	Occupancy daily (%) compared to annual averages
	Waitlist /pending referrals compared to annual averages
Monthly	Occupancy – average bed %,
	Average length of stay (LoS) for month of those that have exited in the reporting period compared to annual averages
	Waitlist /pending referrals
	Reason for admission / extension
	Referrals accepted/declined in past calendar month
Quarterly	Occupancy %,
	Number of critical incidents, use of restraints, use of safe room,
	Staff sick leave, staffing costs and staff changes,
	Rate of readmission within 10 days of exit for those that have exited in the quarter,
	Rate of extensions per admissions,
	Budget/actual spending
	Number of admissions of children under 12 years of age and average LoS
Annual	Quarterly data, as above, compared to previous three years data
	Total annual admissions by gender, disability status, ATSI / CaLD status and age
	Total annual referrals, investigations of complaints, applications for reconsideration and applications to SAT
	Confidential brief survey of District Directors/Team leaders to assess their views and experiences of KFSCC processes and outcomes including: • referral process (including those that are not progressed) • care plan meeting/s • access to assessments and services for child/young person while in secure care • expected/anticipated goals against outcomes/results • discharge and information provided by KFSCC to support child/young person's planning post secure care.
	Summary of results of survey/interview of children admitted 6 months after discharge
	Annual anonymous KFSCC staff engagement and wellbeing survey

3.4 Immediate outcomes

Consistent with the KFSCC Program Logic, the monitoring of desired outcomes of secure care have been categorised into immediate (short term) and outcomes anticipated over the medium term. For the purposes of the M&E Framework, this comprises the following tiers. The first tier (immediate Outcomes) is recommended for adoption. The second tier (medium-term Outcomes) is an option for consideration by Communities.

Outcomes within secure care aligned with the immediate Outcomes of the Program Logic

Outcomes post secure care with the medium-term Outcomes of the Program Logic (see Section 3.6)

Provided in the following table is a description of the Outcome, relevant indicators, the data source for the indicator/s, who is responsible for the data collection and timeframes applicable to monitoring and assessing performance against each Outcome.

Immediate outcomes within secure care			
Outcome 1: That the intent of the secure care admission and goals in a child/young person's therapeutic plan are met.			
Program Logic **Outputs: Therapeutic response plan, Safety Plan, Stabilisation, Discharge Summary**			
Key Indicators	**Data Source**	**Responsibility**	**Timeframe**
Decrease in Risk	• Standardised risk assessment tool (e.g., Short-Term Assessment of Risk and Treatability: Adolescent Version for 12years and over)	Appropriately trained and accredited KFSCC staff members	On entry, extension if provided, and discharge.
Decrease in critical incidents	• Register of critical incidents, use of safe rooms and restraints	KFSCC	At designated time periods throughout secure care period
Stabilisation of problematic behaviour (aggression, anger, violence)	• Summaries from SCOs daily rating scales 'measurable case notes outcomes' (subject to further validation)	KFSCC	Collated during secure care period

Reduction in psychological distress	• Outcome of mental health assessment conducted in secure care	KFSCC Clinical Psychologist	Prior to exit from secure care (can be used to compare to risk profile and mental health status identified at initial care plan meeting)
Evidence of improved self-regulation (emotional and behavioural)	• Summaries from SCOs daily rating scales 'measurable case notes outcomes' (subject to further validation	KFSCC Clinical Psychologist	On entry and at completion of secure care period
	• Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)	KFSCC SCOs	
	• Rate and rationale of readmissions and extensions for child/young person	KFSCC Management	At extension or readmission
Improved physical health	• Physical health details recorded at admission (pre) • Discharge summary including medical summary (post)	KFSCC Medical staff	Commencement of secure care period End of secure care period
Improved awareness/ understanding of protective behaviours, harms associated with alcohol and substance misuse/anger management (Where applicable)	• Pre and post unmet needs analysis and care planning document	KFSCC staff	At the start of psycho-education activities and brief interventions and at the end of secure care period.
Willingness to re-engage into education	• Education needs assessment	KFSCC Education Officer	During the secure care period
	• Observations from Education Officers	SSNBEN	
Reporting: For each secure care admission all data collected for the key indicators would be compiled and utilised by KFSCC Management and provide feedback on each child's progress and allow for evidence-based decisions about the needs of the child.			

3.5 KFSCC service improvement plan

Linked to a quality assurance and improvement framework is a process to reflect on findings or outputs of the M&E Framework for the KFSCC. The collection of baseline data will allow for the evidence-based evaluation of initiatives and modifications and, where appropriate, the opportunity to compare with other similar services.

Such mechanisms should include 'self-evaluation' sessions where staff reflect on what they consider the secure care service does well, and what it could do better. When collated with other stakeholder views this information can be fed directly into a KFSCC *Service Improvement Plan* - with specified target dates for actioning and allocated responsibilities. The Service Improvement Plan would be reviewed annually.

The aim and steps are summarised as follows:

Aim: To engage KFSCC staff in identifying ways to improve the delivery of service and achieve the Vision and purpose of the KFSCC.

The first step is to identify: ***What do we do well and where can we improve?***

For example, agreed priorities could include

- Ensure and enhance the safety, wellbeing, and stability of all young people in secure care.
- Engage young people in planning and decision-making about their lives.
- Provide meaningful activities that foster self-worth and confidence and enhance independent living skills.
- Support and enhance young people's future aspirations and sense of hope about their future.
- Provide Aboriginal youth with cultural connection and respect.
- Support meaningful connections to family, community and culture for Aboriginal youth.
- Ensure staff are well trained and supported (Aboriginal cultural competency training, mental health first aid, Intellectual disability training etc.).

Upon identifying the Agreed Priorities, a process would be undertaken to develop the Service Improvement Plan that identifies the strategies, relevant timeframes to implement and responsibilities.

KFSCC Management would be responsible for the implementation of the Service Improvement Plan with its content and the strategies and activities developed and undertaken by nominated appropriate KFSCC staff. The status/outcomes achieved from implementation of the Service Improvement Plan would form the basis of a status report from KFSCC Management to Communities as a component of the M&E Framework annually.

3.6 Medium-term outcome evaluation – for consideration

Medium-term Outcomes post-secure care

With regard to monitoring and evaluating outcomes and effectiveness of processes and planning for children in and post secure care, the following are provided for further consideration.

I. Collating data against a set of key indicators for the under 12 year old admissions to secure care. This cohort is of particular interest given the early onset of their problems and the understanding that the original intention of establishing secure care did not include this age range. The Evaluation acknowledges that KFSCC has no control and little influence over events that occur once a child leaves their care.

   Collation of data would be based on application of the NAT data pre- and post-secure care admissions and ongoing monitoring of the NAT data to establish a basis from which this cohort can be tracked over the longer term. This would be seeking to establish greater understanding of the trajectory of this critical cohort and account for the fact that many of the standardised assessments cannot be applied with this age group. The Evaluation would also recommend consideration be given to Communities establishing a research partnership for a longitudinal research project involving linked data with this cohort in care.

II. Measurement of a young person's perception of their current wellbeing to access their views. Outcomes from the wellbeing survey may not be solely related to the secure care arrangement but can be used as an additional perspective on the child's wellbeing (in addition to the results from the NAT data) and provide Communities with enhanced understanding and insights into the social and emotional status of young people in their care with extremely complex needs.

This is provided to Communities as an option, however, would require further discussion to assess its utility – given it requires measurement of indicators post exit from secure care.

Medium-term outcomes post-secure care for under 12 year olds

Outcome 2: That the child no longer meets the threshold for admission to secure care •

Program Logic

Medium-term outcomes: Positive destinations

- Appropriate living/care arrangements
- Positive engagement with external support agencies (where necessary)
- Re-engagement with education and the community
- Living safely in the community.

Key Indicators	Data Source	Responsibility	Timeframe
Placement of Aboriginal and Torres Strait Islander children according to Aboriginal and Torres Strait Islander Child Placement Principle	Needs Assessment Tool (pre and post secure care) Results of Strengths and Difficulties Questionnaire (pre and post secure care)	Caseworker	For a 12-month period following exit from secure care.
Reduction in rates of absconding			
Reduction in the use of illicit substances			
Reduction in psychological distress			
Improved self-regulation (emotional and behavioural)			
Reduction in contact with Police and juvenile detention			
Sustained stabilisation in identified problematic behaviour (aggression, anger, violence)			
Evidence of practising protective behaviours and safe and healthy choices			

Re-engagement with education and maintenance of an acceptable level of attendance/engagement			
Engagement with mental health services			
Absence of particular physical health conditions (identified during secure care)			
That OoHC placement instability is reduced (# placements following secure care and length of time in High needs placement where applicable)			
Perception of child's wellbeing			
Reporting: Summary of relevant NAT data provided to KFSCC and Communities to provide for a means of closely monitoring the under 12 year old cohort and provide greater understanding of whether secure care is an effective intervention and the effectiveness of post secure care planning. Including support services and appropriate placement.			
Medium-term outcomes post-secure care – wellbeing			
Outcome 3: That a child/young person's perception of their wellbeing is enhanced			
Program Logic **Medium-term outcomes:** Enhanced health, social & emotional wellbeing			
Key Indicators	**Data Source**	**Responsibility**	**Timeframe**
That a child/young person's perceived wellbeing has improved including safety, relationships, autonomy, and physical health	To supplement the NAT data on wellbeing, use of a purposive/validated survey tool* that facilitates reflection by a young person about whether they : • feel safe	Caseworker to ensure young person completes the survey and results are uploaded on the case file	Approximately 6 months following exit from secure care

	• access meaningful and positive relationships with a peer/s and an adult/s • have a sense of ownership and control over their lives • feel they have strategies for dealing with problems and challenges • access activities that they enjoy and are meaningful to them (culturally specific for Aboriginal youth).		
**Suggested survey tool: The Personal Wellbeing Index – School Children. This measure has been validated with a range of Australian school-aged children, including Aboriginal and Torres Strait Islander adolescents, and young people experiencing hardship and marginalisation. The Personal Wellbeing Index – School Children comprises questions that cover seven areas of wellbeing from the child or young person's perspective. It is completed by young people aged 12 years and older, to reflect their perspective on how satisfied or happy they feel with different elements of their lives. It is important to ensure a survey asks if the young person has engaged in poor behaviours since leaving secure care and what might be the reason/s for that.*			
Reporting: Results to be provided to KFSCC and Communities to establish an evidence base on any outcomes and behaviours sustained post secure care and if the secure care arrangement and/or other factors post secure care contributed to a sustained perception of wellbeing.			

4 Appendices

SEE FOLLOWING PAGES

Appendix A. Overview of secure care models

Following is an overview and comparison of the operating model and facility applicable to the following secure care facilities.

- Kath French Secure Care Centre (KFSSC) – Western Australia
- Secure Welfare Services (SWS) – Victoria
- The Good Shepherd Centre (GSC) – Scotland.

There are some key similarities between the Victorian and Western Australian models of secure care and some key differences between these two jurisdictions and that of secure care in Scotland. These are largely based around:

- the length of stay,
- the admission of children from a juvenile justice context
- whether the secure care centres are a non-government service or are within a government department,
- the purpose of secure care and placement processes for children exiting secure care.

The models of secure care in Victoria and WA that are both government services, have a clear distinction between secure care, mental health facilities and youth detention, with admission criteria that excludes the admission of children via a court decision on criminal charges. It should be noted that there is a provision in Victoria where on nights and weekends if a warrant to return a young person to placement is executed the matter is heard by a rostered Bail Justice who may make a decision to place the young person in SWS rather then return them to placement. These Interim Accommodation Orders (IAO) are always dated to be reviewed by the Children's Court the next business day. Child Protection will attend the Children's Court and either support the extension of the IAO or seek for the young person to be returned to placement. There are a number of IAO's made overnight that are not required to be extended.

Scotland's five secure care units are not for profit entities. While these are not youth offender institutions, or prisons, there are some young people in secure care who are on remand or serving sentences for crimes. This is because there are two methods by which young people in Scotland can be placed in secure care: referral to the Children's Hearings System (CHS) resulting in a Compulsory Supervision Order; committing an offence and being given a custodial disposal by the Court. More than 90% of young people who are in secure care in Scotland are there through the CHS, rather than because they have been remanded or sentenced by the Courts.

In both WA and Victoria, the maximum (without extension) length of stay/secure care arrangement is 21 days and this duration is determined within 48 hours of the child's secure care admission. The secure care period can be extended by not more than 21 days and cannot be extended more than once. However, this does not mean that there cannot be subsequent admissions of a child in a secure care facility. Currently the average length of stay in Victoria is nine days and in WA it is 18 days.

In Scotland a young person's stay in secure care is determined by a set criteria which is reviewed on a three monthly basis at a Children's Hearing - with no time limit on the number of three monthly orders that can be given. The Scottish system is designed to enable sufficient time for robust assessments, interventions and transitions to be put in place, as well as an opportunity for services to accurately

measure the impact and outcomes of all young people accommodated in secure care. For instance, at the Good Shepherd Centre (GSC) a robust assessment process takes place over the first 6 weeks. In the Scottish secure care sector there has been considerable investment in developing specialist intervention services. Clinicians and qualified health and wellbeing practitioners work together across care, education and support services to ensure that there is a health care pathway, in which the individual needs of each young person in secure care are identified, properly assessed and addressed. These processes necessitate a longer-term approach for the secure care arrangement. The average length of stay in secure care in Scotland is four months with some secure care units offering placements for up to 18 months.

Further particulars of the models are set out by the following dimensions or key elements relevant to secure care:

- Mission, Vision & Purpose
- Environment and Facilities
- Management & Staffing
- Service Provision:
- Measuring Youth Outcomes
- Quality Assurance
- Transitions
- Oversight/Regulations.

Information on the Victorian SWS model was obtained via a site visit and the information obtained on the Scottish GSC model was obtained from interviews with the Head of Service of that facility.

A.1 Kath French Secure Care Centre

Dimension	Description
Mission, Vision & Purpose	The Kath French Secure Care Centre (KFSCC) personnel have developed the following Vision: *'To provide a safe, secure environment in which children are cared for within an individualised, trauma informed, therapeutic framework'.* The purpose of secure care is stated in the *Policy on Children Entering Secure Care;* *"to keep the child safe, reduce the risk of harm to the child and others, and return the child to the community as soon as possible in a planned way. Secure care is intended for children aged 12 to 17 years of age.* *Secure care provides planned, short-term intensive intervention in a therapeutic environment to contain, stabilise, assess and support the child's wellbeing".*
Environment and Facilities	In 1999, the Kath French Centre was opened to offer assessment and planning for vulnerable and troubled young people. The building was reconfigured to a secure facility and commenced operations as the KFSCC in May 2011. The KFSCC is located in Stoneville, approximately 40km from Perth Central Business District. The centre accommodates up to six children aged 12-17 and offers the following facilities: • Each child has their own ensuite bedroom. These are spacious, clean and comfortable. • Two small living areas with a television unit, sofa and large beanbag in each. The living areas are sparse with basic furnishings.

<table>
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Two fully equipped kitchens and two dining areas with a table and chairs.
A basic laundry.
Two activity rooms. These areas are used by Secure Care and Education Officers to deliver psycho-educational activities and arts & crafts.
A well-equipped medical room, management / administrative offices and staffing area situated at the front of the building.
A 'Safe Room' is allocated at the back of the building. This is an unfurnished, bare floored, lockable room used to isolate children who are in crisis and whose behaviour has become unmanageable. This room is used voluntarily and involuntarily for children who are unsafe and cannot be safely managed in a less restrictive manner.
Two outdoor areas each surrounded by high security fences. These each have a basketball area (with reasonable sized grassed areas and gardens around the edges and look out over the surrounding bush), table tennis, barbeque and a trampoline.

</td></tr>
<tr><td>Management & Staffing</td><td>
Staffing Structure
Following is an overview of the KFSCC staffing structure (as at July 2018)
<table>
<tr><th>Category</th><th>Role</th><th>FTE</th></tr>
<tr><td>Executive Management</td><td></td><td></td></tr>
<tr><td></td><td>Director</td><td>1.0</td></tr>
<tr><td></td><td>Assistant Director</td><td>1.0</td></tr>
<tr><td></td><td>Sub total</td><td>2.0</td></tr>
<tr><td>Program/Service</td><td></td><td></td></tr>
<tr><td>Health[110]</td><td>Doctor/Nurse Practitioner /Nurse</td><td>0.9</td></tr>
<tr><td>Psychology</td><td>Senior Clinical Psychologist</td><td>1.0</td></tr>
<tr><td>Child Protection</td><td>Senior Child Protection Worker</td><td>1.0</td></tr>
<tr><td>Education</td><td>Senior Education Officer</td><td>1.0</td></tr>
<tr><td></td><td>Sub total</td><td>3.9</td></tr>
<tr><td>Secure Care Officers</td><td></td><td></td></tr>
<tr><td></td><td>Senior SCOs</td><td>5.0</td></tr>
<tr><td></td><td>SCOs[111]</td><td>15.0</td></tr>
<tr><td></td><td>Sub total</td><td>20.0</td></tr>
<tr><td>Admin/Facility Support</td><td></td><td></td></tr>
<tr><td>Meals</td><td>Cook</td><td>1.0</td></tr>
<tr><td>Management Officer</td><td>Maintenance/Roster</td><td>1.0</td></tr>
<tr><td>Administration</td><td>HR/Clerical</td><td>1.0</td></tr>
<tr><td></td><td>Sub total</td><td>3.0</td></tr>
<tr><td></td><td>TOTAL FTE</td><td>28.9[112]</td></tr>
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</td></tr>
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[110] A Consultant Psychiatrist also provides services generally limited to a couple of hours per fortnight

[111] The total FTE count for SCOs includes approx. 20 and 25 casual staff at any point in time. (These casuals are critical in running Secure Care and on average one to three casuals are on each shift.)

[112] In addition, an Aboriginal Practice Leader visits the KFSCC approximately one day per month.

Service Provision:	Model of Care
• Care • Health • Education • Wellbeing Interventions • Behaviour Support	Sanctuary was selected as the preferred model for Therapeutic Care Services in WA as it is a trauma-informed framework for building an organisational culture. It focuses on safety and creating an understanding of how past adversity and trauma can continue to affect someone's behaviour. Sanctuary recognises that trauma has an impact not only on the people who have experienced it, but also on the staff who work with them and on organisations as a whole. Sanctuary is based on a set of guiding principles as well as some specific tools that reinforce the philosophy when practiced by the staff and children on a daily basis. Community meetings are held daily as a tool to bring staff and children together and allow an opportunity to take the "pulse" of the group at the beginning of each shift or beginning a meeting. Self-care plans are used as a visual reminder for both staff and children about the need for each individual to manage and regulate emotions in order to keep themselves and others safe. Staff wear their Self-care cards at all times. Children are supported to create their own unique self-care strategies within the first two days of their stay, these are then printed out and available for the child to refer to whenever they choose. Self-care strategies are raised with the children as a reminder, each time an escalation in their behaviour is observed. Self-care strategies include both activities that one can do alone as well as those that involve others. The activities should be appropriate to the time and place. Sanctuary, together with the principles and practices of Therapeutic Crisis Intervention (TCI) guide the practice and interventions of staff. The philosophical underpinnings of the Sanctuary Model are reflected in seven commitments: • A commitment to Nonviolence • Being safe outside (physically), inside (emotionally), with others (socially) and to do the right thing (morally). • A commitment to Emotional Intelligence • Managing our feelings so that we don't hurt ourselves or others • A commitment to Social Learning • Respecting and sharing the ideas of our teams • A commitment to Democracy • Shared decision making • A commitment to Open Communication • Saying what we mean and not being mean when we say it • A commitment to Social Responsibility • Together we accomplish more; everyone makes a contribution to the organisational culture • A commitment to Growth and Change • Creating hope for the children and ourselves **Care Planning** The Clinical Psychologist compiles a pack of therapeutic planning documents containing extracted information from a child's online file, held by Communities. The pack is usually compiled before a child's admission and contains an individual Safety Plan, Trauma Profile for the child, Medical Issues Form, a Brief History and Therapeutic Response Plan. The pack is emailed to all staff with a printed copy kept in the staff pod for staff to refer to. It is also available on Objective for wider departmental staff.

The primary role of Secure Care Officers is to provide safety through therapeutic interventions and relationships, as well as trauma informed practice. They provide crisis co-regulation for all children as well as physical containment for children who are at extreme risk of harming self and/or others. This is under the guidance of Therapeutic Crisis Intervention practice, with physical intervention being a last resort. Staff assist in meeting the daily needs of each child across all domains (physical, emotional, psychological, social, cultural and environmental). Other tasks include:

- Daily care and support for each child
- Engaging with young people to assist with emotional regulation
- Completion of admission and discharge forms
- Collaborative creation of self-care plans
- Daily case notes,
- Provision of education pertaining to drug/alcohol use and sexual health (as appropriate)
- Participation in delivery of therapeutic psycho-education activities, as listed in the child's Therapeutic Response Plan
- Supporting children with personal hygiene practices
- Providing support with meeting a child's nutritional needs
- Completion of thorough handovers
- Facilitate safe contact with departmental staff, family and services
- Joining outdoor activities including basketball and other outdoor games as well as holding BBQ's and picnics.

The Centre's Director, Assistant Director, Senior Clinical Psychologist and Senior Child Protection Worker attend children's initial planning meeting; progress meeting and exit meeting along with the district care team (Case Manager, Team Leader, District Director, Assistant District Director, District Psychologist, Aboriginal Practice Leader) and any relevant external agencies. The medical team are called in to meetings where the child's medical health is of particular concern. The centre's Senior Clinical Psychologist produces a Discharge Summary at the child's point of exit.

KFSCC 21-day Referral to Exit

Referral Form received from Case Worker (endorsed by District Director)
Referral form is assessed against the criteria for entry by the management team. Queries are fed back to the district as required to obtain further information.
Assessment Form completed by KFSCC Management Team following consultation (endorsed by KFSCC Director). KFSCC Director will then also endorse referral form.
Referral Form and Assessment Form sent to CEO (or delegated authority) for approval
Therapeutic Planning documents compiled
Once approval is received from CEO, transport arrangements commence in collaboration with district, placement and KFSCC.
Child admitted to KFSCC
Admission forms completed by Secure Care Officers
Initial Planning Meeting
Medical Examination undertaken (with consent)
Education Officers and SCO's deliver psycho-education and other informal activities
Progress Meeting
Education Officers and SCO's deliver psycho-education and other informal activities

	Discharge Summary compiled by Senior Clinical Psychologist **Exit Meeting** To be held within the last week before the child leaves secure care

Health

There is 24-hour medical coverage of the centre by either the Doctor, Nurse Practitioner or Nurse, who can be contacted either for advice, information, or to examine a child.

All children are offered the opportunity for a medical examination within 24/48 hours of arrival at KFSCC.

Children are encouraged to make time to see medical staff daily.

Health team meetings occur each Monday – at these meetings, all the children are discussed, and medications / treatments and planning documents are reviewed. Every second Monday, the health team consults with a Child/Adolescent Psychiatrist to assist with children's planning and care. Children's medication is pre-packed in Webster packs and each pack has a designated signature sheet. Clear guidelines are in place for the administration of medication.

Recommended future medical requirements are written into each child's Medical Discharge Summary, and Discharge Summary compiled by Senior Clinical Psychologist.

Education

The KFSCC Education Officers are responsible for provision of selected learning activities and psycho-education to meet the individual needs of each child. Activities are targeted at building the skills and knowledge required for each child, with a focus on developing coping skills. Activities are designed to engage the child in areas of interest. Secure Care Officers are responsible for supporting this process by actively participating in the program with the child.

Reading assessments are undertaken with some children however no spelling, comprehension or numeracy assessments are conducted to establish educational strengths and areas for development.

Wellbeing Interventions

Anecdotal assessments of children's needs and informal interventions to help meet individual target goals (as agreed at the initial planning meeting), are undertaken through the delivery of "Psycho education"[113] ('These activities are listed in each child's Therapeutic Response Plan. Plans also include a section outlining therapeutic conversations to promote growth and change in the children. Progress made is reported on through a Discharge Summary written by the Clinical Psychologist.

The needs of each child are identified through collation of data obtained from a child's file; this includes, but is not limited to, previous trauma history, education reports, placement information, etc. While the majority of children admitted are well known to Communities, with an average of over four years in care, approximately ten percent of children admitted have not previously been in care. As at the date of the Evaluation, Communities has not adopted a standardised risk assessment and management tool that is used consistently.

The Senior Clinical Psychologist uses this information to make a professional and informed judgement about the required interventions that are able to be undertaken during their admission.

[113] KFSCC Management have advised Psycho education is a tool created by Sandra Bloom in her model (Sanctuary) and they consider it is a well-researched trauma informed intervention.

	The implementation of clinical, evidence-based assessments to establish current and long-term needs and risks to help prevent repeat patterns of high risk behaviours is not part of standard practice within the KFSCC. Standardised psychometric assessments are undertaken on request and as required by the Clinical Psychologist. **Behaviour Support** The KFSCC uses Therapeutic Crisis Intervention as a short- and long-term method to: • provide immediate emotional and environmental support to children in a way that reduces their stress and risk • teach better, more constructive and effective ways to deal with stress or painful feelings A Safety Plan is compiled for every child identifying their risks and safety issues, as well as the known triggers for these behaviours. It contains whether the use of physical restraint has been approved and the type of restraint least likely to cause harm. It contains both preventative actions as well as planned responses. When staff complete a Critical Incident Report it is considered in the context of the child's safety and management plans, and in regard to TCI and Sanctuary protocols (e.g., was the planned form of restraint used, were appropriate de-escalation procedures attempted prior). If interventions are not in keeping with the recommendations in the child's Safety Plan, staff are able to incorporate their own risk assessment and rationale into the Report also.
Measuring Youth Outcomes	There is currently no Outcomes Framework in place within the KFSCC
Quality Assurance	There is currently no Quality Assurance system in place within the KFSCC
Transitions	To ensure a smooth transition for children back into the community, a collaborative interagency response regarding the modification of care plans; finding suitable placements for children to be discharged to; establishing educational supports and community intervention packages does not happen on a consistent basis. If a new placement is identified timeously, staff liaise with Care Officers from the new placement and visits are arranged for the new carers to meet with the children before they move on. If possible, they are also provided with photographs of the new placement including their room. Children are unable to participate in transitional visits to new placements before leaving the KFSCC.
Oversight/ Regulations	The KFSCC was established in 2011 under amendments to the *Children and Community Services Act 2004* (the Act). The relevant sections include Part 4, Division 5, Subdivision 3A – *Secure care arrangements*, section 125A regarding the appointment of assessors, and sections 133 and 134A regarding interim orders (secure care) **Governance** Communities has a statutory role to provide secure care for children in WA that meet the admission criteria **Legal Oversight** Only the CEO of Communities (or delegate) can initiate a child's admission to secure care, either through direct admission to the facility or by making an application to the Children's Court. In order to do so the CEO must be satisfied that the following criteria, from section 88C of the Act, are met: *(a) There is an immediate and substantial risk of the child causing significant harm to him or herself or another person; and*

(b) There is no other suitable way to manage that risk and to support the child to receive the care he or she needs

A child or young person admitted to the KFSCC under a secure care arrangement will be either:

- the subject of a protection order (time-limited) or protection order (until 18) (referred to as a "protected child"); or
- in the provisional protection and care of the CEO (and either already the subject of a protection application in the Children's Court or to become one within two working days of admission.

A child or young person may be admitted to the KFSCC under a secure care arrangement via an:

- administrative admission, which occurs for a protected child, or a
- judicial admission, which describes the process required for a child or young person who is in, or is taken into, provisional protection and care.

An *interim order (secure care)* is an order from the Court that the CEO either make a secure care arrangement for a provisionally protected child, or continue a secure care arrangement that the CEO has already made for the child. Application to the Court for a *continuation order* must be made by the CEO as soon as practicable and not more than two working days after the child is admitted.

A protected child or young person under a secure care arrangement may seek a "reconsideration" of the CEO's secure care decision as to the decision to make the arrangement, the duration of the period of the arrangement or a decision to extend the period, under section 88G of the Act. They will be assisted to comply with the requirement for a written application, as required. The child's parents / carers or any other person considered by the CEO to be significant in the child's life, may also apply for a reconsideration of a secure care decision. A "secure care decision" is the secure care arrangement, which is the decision to admit a young person to the secure care facility; the secure care period; any extension of the secure care period. The CEO may then confirm, vary or reverse the previous decision.

In the event that a young person or other applicant is not satisfied with the outcome of the CEO's reconsideration, he or she may apply to the State Administrative Tribunal for a review of that decision.

Regulation

The CEO appoints external assessors who conduct inspections as per section 125A of the *Children and Community Services Act 2004*. They may, at any time, visit the KFSCC and carry out one or more of the following functions:

- enter and inspect the centre
- inquire into the operation and management of the centre
- inquire into the wellbeing of any child in the centre
- see and talk with any child in the centre
- inspect any document relating to the centre or to any child in the centre

Although each assessment report states on the front page that it is an 'Independent Assessment Report', it should be considered that external assessors are appointed by the CEO through a tender process.

A.2 Secure Welfare Services - Victoria

Dimension	Victorian Secure Welfare System
Mission, Vision & Purpose	The aim of the Secure Welfare Services is set out in the Department of Health and Human Services (DHHS) document titled *Secure Welfare Services Operating Model.* The aim is stated as "to keep the young person safe while a suitable case plan is established to reduce the risk of harm and return the child or young person to the community as soon as possible in a safe and planned way" The principal objective of the services is crisis stabilisation. Placements aim to return a child or young person to a community placement at the earliest possible opportunity. The operating philosophy is based on creating a culture and ethos that provides young people the opportunity to stabilise their current state of crisis and plan their return to the community in a collaborative way with the respective Care Team. In this regard the SWS model will strike a balance between the need for a safe and secure environment with one that recognises the need of planning for the best interests of the young person and their return to their community. Reflected in the "vision" are the following principles: • a model compliant with legislation and evidence-based; • quality services that are focused on developmental needs; • a safe and secure environment that allows young people to stabilise; • connectivity to community and family; • flexible and modern approach to managing young people; and • an approach to service delivery that carefully targets risks and needs of individuals.
Environment and Facilities	The secure welfare services in Victoria are provided through two facilities located approximately 8 km North-west of Melbourne CBD in Ascot Vale and Maribyrnong. The Maribyrnong Unit (Girls) is a purpose-built facility whereas the Ascot Vale Unit (Boys) facility (appears to originally have been residential accommodation circa 1930's) has been modified to a secure care format. Both the Ascot Vale and Maribyrnong facility are 10-bed gender-specific residential units for children/young people aged 10 to 17 years. The general configuration of both facilities is similar and comprises: • Seven bedrooms in each facility consisting of four single bedrooms and three double bedrooms). Five of the bedrooms have an ensuite and two of the rooms function as observation rooms where applicable. • The layout of both facilities includes an education room, art room and two activity rooms. • Access to outdoor and recreation areas. • Dedicated kitchen and meals area. • Dedicated medical and allied health area. • Multiple indoor recreation and leisure areas. In general terms, both of the Victorian facilities are materially similar in their configuration to that of the KFSCC facility. However, two differences of note between the facilities are summarised as follows: • Entry to the Victorian SWS facilities by young people to the "Admissions Room" is accessed via a purpose built/specific entrance door to the facility – whereas the current building layout of KFSCC usually requires a one side of the external area to be cleared as the transport (van) enters the facilities

<table>
<tr><td></td><td>perimeter and a lounge area is also generally required to be cleared during an admission process.
• The Victorian SWS facilities have a somewhat better layout to enable movement of staff, and access by staff, to various sections of building separate to that of young people admitted to the facility – in comparison the layout of the KFSCC building has limited common passage access and results in access to bedrooms, the kitchen and education rooms via the lounge areas.</td></tr>
<tr><td>Management & Staffing</td><td>Staffing Structure
Following is an overview of SWS staffing structure applicable to both the Ascot Vale Secure Welfare Unit (Boys) and the Maribyrnong Secure Welfare Unit (Girls).</td></tr>
<tr><td></td><td>Similar to Western Australia, SWS in Victoria apply a day shift comprising a Team Leader and five Secure Care Officers. Night shift comprises two Secure Officers to each Team Leader
Cultural Support Workers are available to support young people in SWS from Aboriginal and culturally and linguistically diverse (CALD) backgrounds.

Staff Qualifications
There are no minimum qualifications for employment in SWS however the majority of staff have a Certificate IV in areas including community services, Youth Work, and drug and alcohol counselling.
Training
New staff undergo a two-week induction process comprising:
4 x “shadow shifts”
3 x “classified” days
2 days preventing occupational violence
1 day therapeutic in care training</td></tr>
</table>

Category	Role	FTE
Executive Management		
	General Manager	1.0
	Operations Manager	1.0
	Sub total	**2.0**
Program/Service		
Health-provided by a funded health service	Doctor (20 hrs/week)	0.5
	Nurses:[114]	
	2 x Mon to Friday	2.0
	1 x Weekends	1.0
Psychology[115]	Clinical Psychologist	0.6
Education	Principal/Lead Teacher	1.0
	Teachers x 2	2.0

[114] Provision of Youth Health and Rehabilitation Services (YHaRS). Psychiatrist is booked in by Medical Service as and when required.

[115] Psychology services outsourced to the *Take Two* Program which is contracted to provide consults to 100 youth per annum at SWS (approx. 3 to 4 per week). Assume 3 days /week. Therefore = 0.6 FTE

	Aboriginal Liaison	AL Officer	1.0
	Mental Health secondary consultancy provided by Royal Children Hospital one day per week and provision of psychoeducational programs one day a week addressing key risks leading to SWS admissions		
		Sub total	**8.1**
	Secure Care Officers		
	Team Leaders (TL) x 6	Senior SCOs	6.0
	Day shift SCOs (5 x SCOs per TL) x4	SCOs	20.0
	Night shift SCOs (2 x SCOs per TL) x2	SCOs	4.0
	Casual Staff	Casual staff =12 to 14	8.0
		Sub total	**38.0**
	Admin/Facility Support		
	Practice Leader		1.0
	Business Support/ Administration	BS Officer	1.0
	Security/ Maintenance	Security Facilities Officer	1.0
		Sub total	**3.0**
		TOTAL FTE	**51.1**

Service Provision:

Model of Care

SWS has adopted a trauma informed approach when considering interventions for young people. It aims to provide an integrated and multi-disciplinary approach to support young people to receive the support they require to recover from trauma and build pro-social skills.

The approach aims to achieve an integrated service approach to address a range of trauma issues. Partnerships have been established across the service, Child Protection, Parkville College, health and program providers.

The principal objective of the SWS is crisis stabilisation.

The operating philosophy is based on creating a culture and ethos that provides young people the opportunity to stabilise their current state of crisis and plan their return to the community in a collaborative way with their Care Team.

The SWS operating model aims to deliver a "structured day" with the young person. Monday to Saturday activity consists of two structured education sessions per day (am and pm).

Each day, after education programs have finished the unit staff will engage with young people in a range and variety of activities. This includes cooking, arts and crafts, sport and recreation and creative writing.

Upon placement of a young person within SWS, staff will engage with the individual to:

- work on their plan/goals;
- to motivate the young person;
- to challenge behaviour and support self-responsibility.

All activities, strategies and plans are loaded onto a central database (CRIS), to ensure continuity of care, transition planning and to support quality assurance reviews.

The Department operating SWS was unable to provide statistical/quantitative data for the purposes of the Evaluation and accordingly demographics of children admitted to the SWS, e.g. age, gender, indigenous status, and information on children who may have repeat admissions is not available for inclusion in this document.

However, from discussions with management of SWS, the profile of young people admitted into SWS is considered to be generally consistent with that of secure care in Western Australia.

A key difference however is the average duration of admission which is commented on further in the section below.

Care Planning

A "48-hour planning meeting" is held for a young person admitted to the SWS. The meeting occurs no later than two business days following admission. This meeting provides a framework from which other meetings can be convened and progress in achieving goals reviewed. The aim of the 48-hour meeting is to:

- review the purpose and goals of the placement.
- identify the required length of placement.
- consider safety, care and protection issues.
- determine roles and responsibilities.
- agree on who can visit, call or write to the young person (including, support workers, family, significant others).
- facilitate any assessments and professional engagement that is required.
- develop an exit plan.
- arrange subsequent review meetings if placement is planned to last longer than seven days

Progress reviews are held seven days after the "48-hour" planning meeting and at subsequent seven-day intervals. These weekly review meetings are chaired by the child protection case planner or case manager and involve the same participants as that included in the 48-hour meeting where possible. The aim of the meeting is to:

- review the agreed goals.
- identify progress, risks and barriers to progress.
- further develop transition and exit plan.
- review whether planned professional engagement and family/carer visits have taken place.
- review whether continued consultation with a principal practitioner is required.

The average duration of stay in Victoria is approximately nine days whereas in Western Australia it is approximately 18 days.

The following particulars are likely to contribute the shorter duration in Victoria:

- The primary reason for short placements is the principle of providing a service of least restriction, it is recognised that placing someone in a secure facility should be for the shortest period of time needed to plan for effective risk management of the young person upon their exit
- Capacity issues are often a factor - SWS regularly have to exit young women "early" given there is a need to accommodate another (new) young person into SWS.
- On nights and weekends if a warrant to return a young person to placement is executed the matter is heard by a rostered Bail Justice who may make a decision to place the young person in SWS rather then return them to

placement. These Interim Accommodation Orders (IAO) are always dated to be reviewed by the Children's Court the next business day. Child Protection will attend the Children's Court and either support the extension of the IAO or seek for the young person to be returned to placement. There are a number of IAO's made overnight that are not required to be extended.

- Availability of other service options e.g. if AOD detox bed or mental health bed becomes available for the young person prior to their original exit date, then they would exit sooner.
- SWS is utilised as a "disruption" intervention for "repeat clients" I.e. secure care is used as disruption for those individuals with complex needs engaging in high risk behaviours and where a short-term respite period is required of say three to five days duration.

One matter of interest is the procedure applied by SWS in regard to managing capacity at the two SWS facilities. This is set out in a procedures document and is summarised as follows:

SWS have a procedure (*Capacity Management*) that outlines actions to be taken when a division determines that a young person needs to be admitted to a secure welfare service and the unit is at, or nearing, capacity.

The three key staff responsibilities when considering a situation where SWS is at or near capacity is summarised in the table below. The approach will differ based upon whether a SWS unit's capacity is at seven or alternatively reaches eight (or more).

When a SWS unit's capacity is at seven residents

Staff Position	Role and Responsibilities
Operations Manager	1. On a daily basis, undertake a review of all young people in the SWS unit and advise the General Manager which young people could be considered for exit
General Manager	2. Provide an email update every Thursday and each time a unit reaches seven residents to relevant child protection Operations Managers outlining the status of young people currently in the service and any capacity issues 3. Undertake a review of all young people in the unit when capacity is at seven and, via email alert, advise relevant child protection Operations Managers of which young person could be considered for an early exit if capacity is reached in the unit. The recommendation is to be based on the SWS General Manager's knowledge of young people in the unit at the time, the progression towards meeting placement objectives and their current stability and risk issues.

When a SWS unit's capacity reaches eight residents

- Escalate the email alert to relevant child protection Operations Managers requesting an updated exit plan for identified young people considered appropriate for an early exit.
- Organise a teleconference (to be scheduled for 8.30 am Friday) between all child protection Directors who have a child identified for possible exit and any child pending admission when a unit has reached eight admissions. This is to assist with timely planning.
- Director, Office of Professional Practice, is to:

- Convene a teleconference between relevant Child Protection Directors/Assistant Child Protection Directors if divisions have been unable to agree on the exit of identified young people, if the unit reaches nine residents and an admission is pending, or when the unit reaches ten residents. An invitation is sent to the Director of the Office of Professional Practice (or their delegate).
- If a final agreement cannot be determined by divisional Directors a decision regarding a necessary exit or a suspension on future admissions will be made by the Director, Office of Professional Practice (or delegate) after consideration of the views of Director/s child protection and Director, Secure Services.

How cases will be considered

Cases will be reviewed by their admission date, presenting risk issues on admission, goals met and current presentation to ascertain which young person may safely be placed out of the facility to make room for a new admission. Young people on an interim accommodation order will also be considered for review where appropriate. This requires the child protection practitioner to make an application to return the young person to court.

Health

The health services provided at SWS are delivered by the Youth Health and Rehabilitation Services (YHaRS). It comprises a General Practitioner, Clinical Nurse Manager, General Nurse and Psychiatric Nurse working collaboratively with SWS staff to provide a "wrap- around" service for the young person.

Psychology services are outsourced to an NGO (Berry Street) and operates the *Take Two Program* which is a partnership between:

- La Trobe University: Social Work and Social Policy, Department of Community and Allied Health
- Mindful Centre for Training and Research in Developmental Health
- Victorian Aboriginal Child Care Agency (VACCA)

Take Two are contracted to provide 100 psychosocial assessments within SWS per year).

The objective of the psychology service is to:

- carry out assessments or secondary consults on young people, as per referrals completed by child protection practitioners
- produce an outline of the current presentation of the young person
- make recommendations on required follow up by the child protection practitioner

A Drug and Alcohol counselling service is not directly appointed by SWS, however, alcohol and other drug workers will visit those young people in SWS that already had a counsellor appointed pre entry into SWS. In general, most community-based services do not outreach into SWS, particularly where the community-based service is located in rural Victoria. In general, if a young person is receiving psychological counselling or alcohol and other drug counselling or any other specialist service in the community these services do not outreach into SWS and continue once the young person returns to their placement

On admission each young person meets with a worker from the health service for an assessment of their primary and mental health needs and the development of a healthcare plan. The admission health assessment provides:

- a brief summary report

	• medication and treatment sheets • a recommendation on observation levels • any necessary health alerts and instructions for immediate treatment or management including mental health and self-harm risks. A Health Exit Summary is prepared by the health service prior to a young person's exit, the summary is used to inform child protection practitioners and other relevant services about the young person's health needs to facilitate their ongoing case management. The summary includes: • an overview of interventions and education and any community referrals needed. • information relating to health conditions, allergies, medication and vaccination history. • information regarding services accessed during this admission or previous admissions and external supports. The Royal Children's Hospital provides two outreach services within SWS. The Gatehouse Centre outposts two clinicians one day a week to deliver psychoeducational programs on topics such as safe sex, healthy relationships, violence, and drug and alcohol. The young people get to choose the topic that is delivered each week. There is a structured educational program for each topic delivered by the clinicians. The service rotates across the two SWS, delivering the service one week at the girl's unit and the next week at the boys unit. The Royal Children's Hospital also outposts a clinician from the Intensive Mobile Youth Outreach Service to the SWS one day a week to provide secondary mental health consultations for both the girls and boys unit. The service provides assistance in referring young people for mental health assessments or inpatient treatment **Education** The Department of Education and Training has established Parkville College, a specialist Government School, to provide a daily education program within SWS. Parkville College also provides education to young people who are, or have been, detained in custody. Structured education and activities are run within the hours of 9.30 am — 4.00 pm six days each week. The teaching staff at Parkville College have developed a flexible curriculum to meet students' varying needs and interests. **Wellbeing Interventions** Therapeutic Plans are developed to support SWS staff understand behaviour management strategies to be used with a young person including behaviours and triggers, support needs, goals and timetabling. The Therapeutic Plan is developed by the SWS Senior Practice Leader in conjunction with the young person, SWS staff, significant people in the young person's life from the community, professionals and stakeholders working with the young person and historical information. They are prepared rapidly for all young people who have a history of behaviours of concern that have led to use of restraints in SWS in previous admissions.
Measuring Youth Outcomes	The key KPIs applied by SWS include the following: • Safety outcomes whilst in SWS • Numbers of critical incidents, Restraint and seclusion • College participation • Health Assessments completed • Maintaining operations within budget

Quality Assurance	There is currently no Quality Assurance system in place for SWS. The SWS Performance Governance Group meets quarterly to review performance data for the service, make recommendations for service improvements and formulate strategies to address performance issues SWS must maintain its accreditation against the DHHS Human Services Standards. The service undergoes external audit against the Standards every three years. SWS is oversighted by the Departments Quality and Safety Committee of the Department's Board where quarterly performance reports are reviewed. SWS requires annual accreditation against the State's Child Safety Standards.
Transitions	The transition and exit plan aim to ensure a safe move for the young person to their placement. Each young person exiting has a written plan to support them once they are discharged; aimed at preventing further admissions. These are prepared by the allocated case manager in child protection. The Plan incorporates the outcome of any available assessments undertaken while the young person has been at SWS. The Plan is shared with the young person prior to implementation and their views noted and incorporated into the Plan. Note Health assessments undertaken in SWS are immediately available but AOD or Psychosocial assessments are generally finalized a couple of weeks after the young person has been interviewed and generally not available to SWS as the young person will have exited the service.
Oversight/ Regulations	Placement at the SWS can occur through an administrative decision for children subject to a family reunification order, a care by Secretary order or a long-term care order or via judicial order on an interim accommodation order. Administrative review procedures (internal review of decision or Victorian Civil and Administrative Tribunal review) are available in relation to the decision to place a child at, or exit a child from, a secure welfare service. The *Children, Youth and Families Act* (the CYF Act) 2005 is the legislation governing secure care in Victoria. Under the CYF Act the Secretary of DHHS approves an application if satisfied that there is substantial and immediate risk of harm to the child. There must be court application/order if the child is not already in the care of the CEO. The following must be met before authorisation for a placement at SWS is sought: • placement at the SWS is in the young person's best interests. This means that explicit consideration of the young person's safety and developmental needs demonstrates that placement at the SWS is necessary, and • there is substantial and immediate risk of harm to the young person and no other available support or placement is adequate to protect the young person from significant harm, and • contact has been made with the SWS to confirm that a place is available and that the identified needs of the young person can be met. A child subject to a family reunification, care by Secretary or long-term care order may be placed at a SWS for a period not exceeding 21 days if the Secretary or the court (if the child or young person is subject to an Interim Accommodation Order) is satisfied that there is a substantial and immediate risk of harm. In exceptional circumstances, the period at SWS may be extended for one further period not exceeding 21 days. There is no limit on how many times a young person is admitted to SWS Right of review of a decision to place or exit A person affected by a decision to place (or to not place) a child or young person at, or to exit them from SWS, may request a review of the decision. A person, including a

	child or young person, may request a review of the length of time a child or young person is proposed to be placed at the SWS. Area directors of the Department are authorised to review case planning decisions including SWS placement decisions. Applications for review regarding children and young people placed at SWS are heard by an officer senior to the one who approved the admission. A review of a SWS placement decision should be determined within two business days of being received by the Department.

A.3 The Good Shepherd Centre - Scotland

Dimension	Description
Mission, Vision and Purpose	The GSC mission statement was established when it opened in 2006 and is guided by the following principles: • To create an environment which is non-threatening, accepting, caring, safe and supportive, providing the young person with an opportunity for change. • To create an environment that has both structures and boundaries and at the same time offers a culture of openness and safety. • To create an environment that is robust enough to tolerate the young person's need to test its safety and trustworthiness. • To recognise that each young person is unique with his/her own set of strengths and needs and associated risk factors. • To develop the young person's sense of belonging and their total sense of wellbeing. • To develop an assessment process that promotes understanding of a young person's background, individual needs/deeds and history. • To develop programmes which encourage the young person to address his/her behaviour and maximise the opportunity for him/her to effect positive change. • To provide highly individualised care in a facilitating environment that can be flexible to meet particular needs. • To create an environment and relationships that offer the young person the opportunity to relearn or learn anew about the relationship between thoughts and feelings and his/her experience of other people. • To create a culture that states that any interactions between young people and adults are potential opportunities for enhancing the young person's development. • To commit to open examination and resolution of problems, tensions and conflicts within the group. To have committed, interested, involved and genuinely caring staff. • To be committed to addressing and reducing the risk factors associated with the young person. • To be realistic about what can be achieved in the context of being an important step along the way. The GSC Vision also originates from its opening in 2006: *To create and develop the wellbeing of every young person placed in the Good Shepherd Centre.* Following consultation with staff and young people in 2013, the GSC developed the following purpose statement that clearly defines the intended and specific function of the centre:

<table>
<tr><td></td><td>Our purpose is to provide a positive, life changing experience for young people through individual care, education and skills development
It should be noted that although comparisons made within this report are focussed on the first 21 days of a young person's stay at the GSC, that this statement encompasses the longer term journey (110 days average) a young person is likely to undertake from initial assessment, through to an individualised care and education package, to the development of skills that will enable them to reach a positive destination on exit from the GSC.</td></tr>
<tr><td>Environment and Facilities</td><td>The GSC is set within woodlands, close to a small town. The purpose-built building was opened in 2006. The Assessment Unit accommodates 6 young people aged 12-17 and offers the following facilities:
Each young person has their own ensuite bedroom. These are spacious, clean and comfortable.
A large living area with four 2-seater sofas, 4 chairs, 4 coffee tables, shelving units and a television unit mounted on the wall.
A smaller 'family room' with 4 chairs and a coffee table, where young people can meet and talk to their families and/or social workers.
A fully equipped kitchen and dining area.
There is also a:
fully equipped laundry for young people to use as appropriate.
well decorated, attractive activity room for Arts & Crafts and Play Station games.
large games / library area that is bright and welcoming with beanbags and large 'movie' screen.
Sensory Room which is fitted with calming lights / music and soft furnishings to help young people to relax and unwind.
well-equipped medical room.
fully equipped dental surgery.
large soft surfaced outdoor area with basketball hoop and BBQ area.
Young people living in the Assessment Unit have shared access to the centre's fitness suite; gymnasium; indoor trampoline and Education Department.</td></tr>
<tr><td>Management and Staffing</td><td>Staffing structure
<table>
<tr><th>Category</th><th>Role</th><th>FTE</th></tr>
<tr><td>Executive Management</td><td></td><td></td></tr>
<tr><td></td><td>Head of Service</td><td>1.0</td></tr>
<tr><td></td><td>Service Manager</td><td>1.0</td></tr>
<tr><td></td><td>Sub total</td><td>2.0</td></tr>
<tr><td>Program/Service</td><td></td><td></td></tr>
<tr><td>Health</td><td>General Nurse</td><td>1.0</td></tr>
<tr><td></td><td>Mental Health Nurse</td><td>0.5</td></tr>
<tr><td>Psychology</td><td>Clinical Psychologist</td><td>0.2</td></tr>
<tr><td>Wellbeing Support</td><td>Program Worker</td><td>1.0</td></tr>
<tr><td>Education</td><td>Teachers</td><td>3.0</td></tr>
<tr><td></td><td>Sub total</td><td>5.7</td></tr>
<tr><td>Secure Care Officers</td><td></td><td></td></tr>
<tr><td></td><td>Unit Manager</td><td>1.0</td></tr>
</table></td></tr>
</table>

		Assistant Unit Manager	2.0
		Care Workers	11.0
		Sub total	**14.0**
	Admin/Facility Support		
	Meals	Cook	1.0
	Management Officer	Maintenance	1.0
	Administration	Clerical	1.0
		Sub total	**3.0**
		TOTAL FTE	**24.7**

Day shift levels consist of three Care Workers one of whom may consist of an Assistant Unit Manager

Night shift staffing levels consist of 1 Care Worker and 1 Nightshift Coordinator who works between two other units that provide a staged secure care approach on the grounds of the GSC.

Unit Manager is not unit based unless required and is therefore not counted on shift rotas.

Staff Qualifications

Scottish Vocational Qualification 3 and Health and Social Care Higher National Certificate. If a candidate has only one of these qualifications, they can still apply to the Scottish Social Services Council for registration to work in the GSC. They will receive a time-limited 'condition' from the Scottish Social Services Council and will be supported to gain the relevant qualification whilst working in the centre.

Care Service managers also require a SVQ 4 Health & Social Care qualification.

Training

New staff working in the GSC undertake a four-week in-house induction programme. They undertake training in the following areas:

- Therapeutic Crisis Intervention (4-Day Course)
- Introduction to Risk Assessment (START:AV)
- Safe Care
- Child Protection
- Child Sexual Exploitation
- Medication
- Wellbeing Support Services Awareness
- Mentoring
- Fire Safety
- Secure Care and The Law
- New Children's Hearing Act 2011
- Multi Agency Incident Response Guide Awareness & Emergency Protocols
- First Aid at Work SCQF Level 6 Award
- Trauma, Attachment & Communicate
- Young Minds
- Storm
- Risk Management and Self Harm
- Introduction to Vicarious Trauma
- Missing Person's Protocols – Police Scotland
- Hate Crime – Police Scotland
- Radicalisation – Police Scotland

	• Equality & Diversity Other 'needs led' training is undertaken during bi-annual staff development days and weekly team meetings. Refresher training in TCI, Safe Care and Child Protection is ongoing. New staff complete a 12-week induction pack that aims to provide them with an introduction to the aims, functions and objectives of the GSC, and to become familiar with the people, routine and practices of individual units. Staff training records are held in-house.
Service Provision: • Care • Health • Education • Wellbeing Interventions • Behaviour Support	**Care** *National Care Standards* The National Care Standards against which secure care centres in Scotland are registered and inspected changed with the implementation of new National Health and Social Care Standards in April 2018. New Care Standards specific to Secure Care are currently in draft form. **Model of care** The Model implemented within the GSC advocates adherence to a set of theoretical principles to help inform staff approaches, while retaining the flexibility to closely match interventions to the individual needs and risks presented by young people. The principles that inform the GSC model of care are as follows: • Use of attachment / trauma theory to inform all interventions contained within the residential milieu. This ensures that the staff team have a full understanding of the way in which the young person's experiences can impact on their neurobiological, physical, emotional and psychological development. This also assists staff to choose the best strategy to employ in their attempts to meet the young person's needs and helps them to respect the young person's right to the development of their wellbeing while addressing their risky behaviour. • Focus on risk assessment and risk informed management of the young person's behaviour through de escalatory techniques and promotion of self-regulatory skills. • Promotion of a therapeutic alliance between staff and young people to assist in the modelling of healthy attachments and the development of the young person's sense of physical, emotional and psychological safety. • Focus on skills development with young people through the application of the outcomes framework. This is delivered by staff within the residential milieu to ensure that the young person has their learning reinforced within their living and learning environment. • Focus on integration of interventions by staff, parents and social workers to reinforce positive outcomes. • Focus on participative activities for staff, parents, children and social workers to ensure that they are fully involved in the promotion of the young person's wellbeing. **Care Planning** Broad outcomes (achievable during their stay) are agreed at the young person's initial planning meeting. Every young person has a case team with a 'keyworker' system in place to ensure young people are supported at every point of the day. Key workers are responsible for keeping their young person's case files up to date, writing their interim care plan and writing reports on their progress. Keyworkers (care staff) liaise with Education, Health and Wellbeing staff to ensure agreed assessments and interventions are undertaken. They also liaise with social workers and parents/carers, and organise / attend young people's meetings with external agencies.

They have responsibility for the completion of all young people's logs, paperwork and online work, including Admission forms; Individual Crisis Management Plans (Safety Plan); Time Away Plans; Daily Risk Assessments and Outcomes Framework Data. Care Staff are also responsible for organising evening / weekend / school holiday activities for young people. Weekly activity planners are written in conjunction with young people.

GSC 21 day Referral to Exit

Referral / Note of Authority received from Social Worker	
Chief Social Work Officer / Head of Service agree placement	
Individual Placement Agreement agreed between Local Authority and GSC	
Young Person admitted to GSC	
Admission forms completed by Care Staff	
Initial Planning Meeting	
Health and Mental Health Screening Assessment undertaken	Young person attends Education Department for taster lessons and activities in various subject areas. They also participate in psycho-educational programs (drug & alcohol / sexual health awareness and child sexual exploitation
Care Staff conduct young person's Self and online Wellbeing Assessment	
Care Staff conduct START:AV Risk Assessment	
Education Staff conduct Education Assessment	
Progress Meeting	
Assessment Report Compiled by Care Staff	
Exit Meeting	
Discharge Summary finalised by Care Staff	

Health

There is medical coverage of the centre Monday to Friday 9am-5pm by the Centre Nurse. Outside of these hours National Health Service 24 can be contacted either for advice or information.

The centre nurse undertakes / organises health assessments for all young people soon after their arrival at GSC. This includes medical, dental and optical. Every young person undertakes a HADS (a recognised depression scale) mental health screening.

The centre Nurse and Mental Health Nurse attend multi-disciplinary meetings along with the Service Manager, Clinical Psychologist, Education Manager, Wellbeing Manager, external consultants (CAMHS) and Unit Manager to discuss young people's medications / treatment / behaviour / intervention / education plans.

The centre nurse manages young people's medication and clear guidelines are in place for the administration of medication.

Health reports are incorporated in to each child's Assessment Report.

Education

The GSC Education department undertakes a full educational assessment of every young person with a concentration on Literacy, Numeracy, Health & Wellbeing and future aspirations. A comprehensive educational assessment report is produced within a three week period. All reports utilise a tracking and monitoring system based around the Scottish

	Government's National Priorities in Education. This system allows the Centre to identify the young person's strengths & development needs and how to address these. It is recognised that many of the young people are disengaged from education due to prior experiences, therefore it is fundamental to re-engage the young person in the educational process through the provision of a bright, positive and supportive environment. If it is determined that a young person will stay past the initial assessment period of six weeks, they will have the opportunity to undertake learning in every area of the Scottish curriculum (Curriculum for Excellence). In addition, they will be afforded the opportunity to participate in wider achievement learning such as outdoor education & vocational awards. Further to this young people are encouraged to 'learn how to learn' through distance learning courses. The centre also works in partnership with local colleges and training providers who are utilised to offer further learning opportunities. Every learning activity is planned and learning intentions are shared with the young person. All learning can lead to nationally recognised attainment and a major focus of the young person's individualised education programme is to raise self-esteem and confidence. There is a high attendance rate with many young people attending education 100% of the time. The mean attendance is over 90%. Young people are supported educationally by residential care workers in evenings and weekends through a LACE (Learning through Care & Education) initiative. **Wellbeing Interventions** The GSC works to the premise that a rigorous assessment of a young person's risks and needs has to be undertaken before formal interventions are identified. Therefore, following the initial assessment period, every young person within the GSC has a bespoke intervention package tailored to their individual risks and needs. Interventions within the GSC are described under 5 categories: • Cognitive Behavioural Interventions – Cognitive Behavioural Interventions are evidence-based programs which can lead to positive change for young people who undertake the programme. The success of the program is influenced by both content and the relationship between young person and the program staff. Evidence, however, points to efficacy of the program independent of the latter factor. • "What Works" Programmes – Theses are programs based upon Cognitive Behavioural Theory. • Psychosocial Education Programs – These programs provide skills and knowledge in relation to identified issues. Although not evidence based they can provide the young person with skills and knowledge that could lead to positive change. These programs may be delivered by members of the Wellbeing Support Team or by Education Staff. • Skills Programs – these programs provide young people with skills applicable to leisure and other activities resulting in increased self-efficacy and Hope for the participant. • Wellbeing Programs – These programs are designed to reduce stress and anxiety in young people with the resultant outcome of making the young person more responsive to undertaking other programs and interventions. *All interventions will be undertaken on the premise that the young person will be Ready (the intervention has to be scheduled at the right time for the young person), Willing (the young person must have the motivation to engage) and Able (the young person must be capable of understanding and accessing the content of the intervention).

	A majority of the programs can generate evidence which allows for certification through the Scottish Qualifications Authority either through a Problem Solving Unit, a Self-Awareness or specific Scottish Qualifications Authority qualifications. **Behaviour Support** The GSC uses Therapeutic Crisis Intervention as a short- and long-term method to: • provide immediate emotional and environmental support to children in a way that reduces their stress and risk. • teach better, more constructive and effective ways to deal with stress or painful feelings. An Individual Crisis Management Plan is compiled for every young person identifying their potential triggers, high risk behaviours and intervention strategies.
Measuring Youth Outcomes	Getting it Right for Every Child (GIRFEC) is Scotland's national practice model that aims to provide children and young people with a better future. Under GIRFEC, eight wellbeing indicators have been identified as areas in which children and young people need to progress in order to do well. The eight indicators are collectively known as SHANARRI: Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included. Research indicates that the domain of Hope is also of great importance to the development of a young person's wellbeing and so the GSC has added this. The indicators are used to provide evidence of the progress that each young person makes during their placement in GSC. These indicators are measured through the use of questionnaires for young people, families, social workers and staff. Further data relating to the subjective wellbeing of young people is collected online and used to inform our interventions. Each domain utilises multiple empirical evidence sources which are averaged to provide a grade of between 1 and 6 (where 1 is low and 6 is high).
Quality Assurance	The centre applies the use of a Service Improvement Plan (SIP) that follows a 3-year cycle and is reported on through a Service Standards & Quality Report (SSQR). The SIP is organised under the national wellbeing indicators (SHANARRI) with the addition indicator of Hope. This ensures that all Service improvement strategies over a calendar year are determined by the degree to which they could improve the wellbeing of the young people and the staff who deliver the service. Care and Education improvement plans are integrated within the SIP and are reported on annually within the. The findings of the centre's ongoing research programme, as gathered through the young people's online assessment of their wellbeing, are incorporated into the SIP. The strategies and goals that form the basis of the SIP are developed as part of a consultative exercise with all staff, managers and senior management. Data from the centre's Wellbeing Outcomes Framework is based on the views of young people, families, staff and stakeholders. The aggregate data provided by this exercise is collated and analysed annually. Suggestions from both sources are added to those strategies carried over from the previous year's SIP. A target of 70% has been set by the Senior Management team in terms of the percentage of strategies considered to have been "achieved" at the end of each SIP.
Transitions	The GSC adopts a 4-stage transition plan:

Stage	Actions
1	• Admission to GSC • Initial Assessment undertaken • Transition Planning commenced

	2	• Personalised curriculum • Career Planning
	3	• Preparation for Transition to positive destination
	4	• Positive Destination
	Within the initial 3-week assessment period it is expected that stages 1 & 2 will be completed. A further placement within the Centre allows for robust planning to be undertaken, ensuring that stages 3 & 4 are completed, and a young person is able to transition to a positive destination with an increased probability of sustaining the placement. A transitional plan is formulated for each young person in the first week of their arrival. This is a dynamic document which changes in accordance with a young person's plans. Young people moving on to a new unit or back into the community after their initial assessment will undertake transitional visits before the final move.	
Oversight / Regulations	The GSC is an independent charitable organisation which became a Company Limited by Guarantee in 2012. The Children's Hearings (Implementation of Secure Accommodation Authorisation) (Scotland) Regulations 2013 (the Regulations) set out the definitions and parameters of secure care. **Governance** The GSC is administered under the Children and Families Directorate of the Scottish Government. The organisation is governed by a Board of Directors made up of voluntary professionals who are responsible for the operation, financial and professional management of the centre. **Legal Oversight** There are two methods by which young people in Scotland can find themselves in secure care: • Referral to the Children's Hearings System resulting in a Compulsory Supervision Order (CSO). • Committing an offence and being given a custodial disposal by the Court. The Children's Hearings System has responsibility for dealing with most children and young people under 16 years of age who commit offences and/or who are in need of care and protection. For children who commit very serious crime there is an option for them to be jointly reported to the children's reporter and the procurator fiscal and together they will decide whether prosecution through the court is appropriate. The court may then sentence, or alternatively return the young person to the hearing to be dealt with. Scottish Ministers are responsible for children under the age of 16, and young people aged 16 to 18, who are on Compulsory Supervision Orders, sentenced under solemn procedures (the most serious criminal cases) and placed in secure care. Local Authorities are responsible for children and young people who enter secure care through the Children's Hearing System. The Children's Hearings (Scotland) Act 2011 provides the legal oversight, including specific conditions and the 'secure care criteria' which must be satisfied before an order with authorisation for placement in secure care is made, i.e. *(a) That the child has previously absconded and is likely to abscond again and, if the child were to abscond, it is likely that the child's physical, mental or moral welfare would be at risk.* *(b) That the child is likely to engage in self-harming conduct.*	

	(c) That the child is likely to cause injury to another person. When a children's hearing issues an order, with secure authorisation, there is a second stage of decision making. The Local Authority Chief Social Work Officer and the Head of the Secure Care Centre have certain powers and duties in relation to whether the secure authorisation is implemented. **Regulation** The GSC is regulated under the Public Services Reform (Scotland) Act 2010 and the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. The centre is registered, regulated and inspected by the Care Inspectorate who provide oversight functions of secure care units and are an independent body and report against the National Health and Social Care Standards. These reports are made publicly available and also grade the effectiveness of secure care units is subject to an annual, unannounced inspection and graded under the following quality themes: • Care & Support • Staffing • Leadership & Management • Environment. Education Inspections are carried out every 4 years and the centre is graded against the following Quality Indicators from the National Inspection Framework 'How Good is Our School': • 1.3 Leadership and Change • 2.3 Learning, Teaching and Assessment • 3.1 Ensuring Wellbeing, Equality & Inclusion • 3.2 Raising Attainment and Achievement • Plus an additional QI negotiated with the school (not graded) • Plus 2.1 Safeguarding & Child Protection (not graded) • Plus Themes (changed annually, not graded)

Appendix B. Literature Review

Department of Communities

Evaluation of the Kath French Secure Care Centre

Literature Review

13 June 2018

Version 3

Table of Contents

Introduction

The purpose of this literature review is to establish the background and conceptual framework for an evaluation of the Kath French Secure Care Centre (KFSCC). The literature review begins with a brief overview of the out-of-home care system, the role of secure care and the cohort of children it is designed to serve. It then outlines the components of secure care at the KFSCC and compares aspects of other programs and secure care centres in Australia and overseas. The review then identifies key issues that dominate the literature on secure care and evidence of good practice approaches to delivering and measuring secure care services.

Overview

In Australia the number of children and young people entering the child protection system, including Out-of-home care (OoHC), is steadily growing. In 2016–17, 168,352 (1 in 32) of all children in Australia had an investigation, care and protection order and/or were placed in out-of-home care. Aboriginal and Torres Strait Islander children were seven times as likely as non-Indigenous children to have received child protection services. The median age of children in care was eight years old for both Indigenous and non-Indigenous children. The rate of children in OoHC at 30 June rose, from 7.7 per 1,000 in 2013 to 8.7 per 1,000 in 2017. Overall, 7,366 more children were in OoHC at 30 June 2017 compared with 30 June 2013, an 18% rise. [116]

Some children are placed in OoHC because they were the subject of a child protection substantiation and need a more protective environment. Children may also be placed in OoHC when their parents are incapable of providing adequate care for them, or when alternative accommodation is needed during times of family conflict. There is no national data available on the reasons children are placed in out-of-home care. Aboriginal and Torres Strait Islander children (13.6 per 1,000) were 10 times as likely as non-Indigenous children to be admitted to OoHC during 2016–17 (1.4 per 1,000).

Children are being admitted to OoHC at a younger age and remaining there for longer. Of the 47,915 children in OoHC at 30 June 2017, most (83%) had been continuously in OoHC care for 1 year or more. This included: 27% who had been in OoHC for 2 –5 years, 41% who had been in OoHC for five years or more. About 17% of children had been in OoHC for less than 1 year. These timeframes were similar for both Indigenous and non-Indigenous children.

The profile of children and young people in OoHC is also becoming more complex, both systemically and clinically.[117] Many children enter care with a high risk of Post-Traumatic Stress Disorder diagnosis and

[116] Australian Institute of Health and Welfare 2018. Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW.

[117] Fahey, L. (2014). "Who cares": the impact of carer trauma and resilience profiles on capacity to support young people with complex support needs (Doctoral dissertation, University of Western Sydney (Australia).

mental health problems.[118] This is not surprising given that by the time a child has entered the care system, they may have already been exposed to multiple traumatic experiences including abuse, neglect, exposure to domestic violence, a family history of mental health, and drug and alcohol abuse. Children and young people whose histories have resulted in removal to foster or residential care settings, and who experience multiple changes in caregiver, often face substantial barriers in experiencing consistent secure attachment with a primary caregiver. The developmental significance accorded the presence of at least one secure attachment during childhood means the consequences of its absence can be pervasive.[119]

Children can also experience further trauma whilst in OoHC as a result of abuse. Children in OoHC are deemed highly vulnerable, as separation from their family, and instability of placements can leave them isolated, and lacking established relationships with trusted adults[120]. This all contributes to an OoHC system that needs to respond to children with high rates of trauma and behavioural problems. While the needs of children in care are increasingly being conceptualised as a spectrum of needs across a range of domains, there are a cohort of children whose needs are so complex and extreme they can impact on their daily functioning and significantly affect their behaviour, sometimes in potentially life-threatening ways. In some places, these children are placed in secure care.

A number of inquiries and statutory reviews have been undertaken into child protection, youth justice systems and institutional responses to children at risk. Annexure A provides an overview of the findings and recommendations (that have some nexus to this Literature Review) from a selection of recent inquiries and reviews. Some of the themes identified across all these inquiries include:

- requirement for trauma informed, therapeutic models embedded within all out of home residential care as well as secure facilities
- the need for independent oversight and monitoring, evaluation and review of care facilities
- sectors and agencies working collaboratively to provide integrated, comprehensive services that meet the complex needs of children and young people, especially when they are transitioning out of secure arrangements.

The findings are further considered in the following sections of the Literature Review.

Role of Secure Care

Secure care is a complex, multi-faceted intervention that serves children and youth with high levels of risk. It is designed to provide care and control and also to effect behavioural change.[121] In those countries, states and territories where it is utilised it is conceptualised as part of the continuum of residential care options and services for children mostly in OoHC, with some exceptions, but is also the most extreme

[118] Salazar, A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older adolescents in foster care. Social psychiatry and psychiatric epidemiology, 48(4), 545-551.

[119] Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. Infant mental health journal, 22(1-2), 7-66.

[120] Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report. Commonwealth of Australia, 2017.

[121] Walker, M., Barclay, A., Hunter, L., Kendrick, A., Malloch, M., Hill, M. & McIvor, G. (2005). Secure accommodation in Scotland: Its role and relationship with 'alternative' services. Edinburgh: The Stationery Office.

form of protective intervention. Secure care is regarded as an appropriate support response for a small cohort of children and young people whose extreme behaviours make them a danger to themselves.[122]

Secure care facilities are regarded as serving a purpose for a small cohort of children and young people who are in an OoHC setting that cannot adequately care for and support their immediate needs, the result of which not only increases the trauma for the child/young person, it can also contribute to significant problems in the out-of-home care system.[123] These problems include multiple placement disruptions and breakdown, contagion and vicarious trauma, where other children and young people in the placement are impacted by the often distressing behaviours of the child. This causes issues for the individual child or young person, for the other children and young people around them and for the staff. Ultimately, it also causes problems for the overall system due to the breakdown of efficacy of treatment for children in the extreme cohort.

Children and young people in secure care are likely to have significant mental health concerns and possibly cognitive impairment that can manifest in communication disorders, mental health disorders and post-traumatic stress disorder. These children and young people may also be living with an 'invisible' or undiagnosed neuro-disabilities such as Foetal Alcohol Spectrum Disorder, Autistic Spectrum Disorders, traumatic brain injury, Attention Deficit Hyperactivity Disorder and learning disabilities.[124] While there may be a particular crisis that leads to an application for secure care, children and young people in the target group will often have a history of chronic risk taking behaviour that places them at significant risk of harm. Children and young people within this target group might also have multiple challenging behaviours, including sexual, and may have been resistant to previous interventions.

Therapeutic Secure Care in Australia

Therapeutic based secure care (as opposed to secure care in a mental health or juvenile justice context) is relatively new in Australia. It has emerged along with an increase in the establishment of trauma-informed therapeutic services across Australia over the past 15 years. This is largely due to the availability and prevalence of international research regarding the impact of trauma on childhood development and the understanding of how a trauma-informed service system can assist children to overcome adverse experiences. Such services attempt to address the underlying causes of the child or young person's behavioural and emotional difficulties.

Therapeutic residential care including secure care has been heavily informed by attachment theory, trauma theory, the neurobiology of attachment and trauma, self-regulation, the concept of resilience,

[122] Barclay, A. & Hunter, L. (2008). Blurring the boundaries: The relationship between secure accommodation and 'alternatives' in Scotland. In A. Kendrick (Ed.), *Residential childcare: Prospects and challenges*. London: Jessica Kingsley Publishers.
[123] Mercy Family Services (2012) A Series of Papers examining Critical Issues in Child Protection. Brisbane: Mercy Family Services.
[124] Fahey, L. (2014). "Who cares": the impact of carer trauma and resilience profiles on capacity to support young people with complex support needs (Doctoral dissertation, University of Western Sydney (Australia); Passmore, H. M., Giglia, R., Watkins, R. E., Mutch, R. C., Marriott, R., Pestell, C., ... & Freeman, J. (2016). Study protocol for screening and diagnosis of fetal alcohol spectrum disorders (FASD) among young people sentenced to detention in Western Australia. *BMJ* open, 6(6), e012184.

behaviour modification, cognitive behaviour therapy and anger management.[125] The aim of any therapeutic care service is a therapeutically-based intervention to provide intensive support to enable traumatised children to begin to manage their emotions and behaviour. Critical to a therapeutic setting is a treatment, as opposed to a punishment, mindset to a child's behaviour. This includes separating offending behaviour from trauma-related behaviour especially when the two often co-occur.

Components of therapeutic secure care programs tend to include:

- the creation of a safe, stable, consistent and therapeutic living environment;
- comprehensive needs assessment;
- individualised case planning based on identified needs and strengths and subject to regular monitoring and review involving the child or young person's family and professionals from a range of disciplines;
- a multidisciplinary care team approach involving highly skilled direct care staff who work collaboratively with a range of professionals to achieve the child or young person's therapeutic and other goals identified in their case plan;
- planned day programs, including education, incorporating the child or young person's therapeutic and other goals identified in their case plan;
- regular contact between the child or young person, their family and significant others where appropriate;
- maintenance of the child or young person's community and cultural connections as far as possible;
- regular involvement of a caseworker; and,
- comprehensive transition planning and support for exiting the program and secure care setting.

Treatment Services in WA for Youth with Extreme Complex Behaviours

A number of services and initiatives operate within Western Australia that focus on children and youth with extreme complex behaviours. An overview of a selection of these services is contained at Annexure B of the Literature Review. In general terms, the services have the following attributes:

- provide intensive, therapeutically based and trauma informed programs
- utilise a multidisciplinary team
- largely service the Perth metropolitan area
- are non-residential services utilising outreach or day programs (except Parkerville and the State's specialist mental health units at Bentley and the Children's Hospital).

[125] McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, Australia.

Secure Care in Western Australia: The Kath French Secure Care Centre

Establishment

The Ombudsman of Western Australia's Report on Allegations Concerning the Treatment of Children and Young people in Residential Care (2006) and Prudence Ford's subsequent review of the then Department for Community Development (2007) both identified the need in Western Australia for a secure care facility for children in care. Ford recommended a three- tiered system of residential care in which a secure care facility would meet the needs of a small group of young people who present a substantial and immediate risk of causing significant harm to themselves or others, where there is no other way to manage that risk and ensure that they receive the care that they need. Ford also noted the need for an evidence based therapeutic model, staffing model and competence-based training that reflected the therapeutic approach to services. Ford recommended the Kath French Centre become an intensive therapeutic unit for children aged 12-17 years in care.[126]

In May 2011, the Kath French Secure Care Centre (KFSCC) in Stoneville commenced operation as Western Australia's first secure care facility staffed by a multidisciplinary team where children would be provided with up to 21 days of intensive support. In 2013, bed numbers at the centre were reduced from nine to six and the number of staff from 33 to 28. The centre is intended to provide some of Western Australia's most vulnerable children in OoHC with their best opportunity to stabilise and begin to address the complex problems and behaviours that prevent them from maintaining longer term placements and transitioning to more independent living.

Parliamentary Processes

The Children and Community Services Act Amendment Bill (2010) sought to introduce "a suite of amendments to improve and strengthen the operation of" the CCSA 2004.[127] The two major new developments outlined in the legislation were the establishment of a secure care facility for children and young people at extreme risk, and the introduction of special guardianship orders for children who were unable to live permanently in the care of their own families.

In the Bill's second reading speech, the Parliamentary Secretary noted the need for a secure care facility had "long been deliberated" in WA and had been raised in a 2006 Ombudsman report and a 2007 review of the Department for Community Development. He suggested the model introduced in the Bill was largely based on Victoria's model.[128]

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[126] Department for Child Protection and Family Support (2016). Review of the *Children and Community Services Act 2004*: Consultation Paper. Perth, Western Australia, p.27.

[127] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr A. J. Simpson, p6962b-6991a,

[128] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr A. J. Simpson, p6962b-6991a

Parliamentary debate at the time reveals some members felt some unease with the concept of placing children in secure care, especially in the context of increasing revelations about abuse in care. One member felt establishing a secure care facility was "potentially a dangerous concept... All sorts of things can happen behind closed doors... Although there may be reasons for this facility, alarm bells ring in my head at the potential for abuse."[129]

The Parliamentary Secretary was thus at pains to point out a secure care facility was to be an "*an option of last resort for managing the highest levels of risk that some young people*" present. It was to be used only when the "CEO or the Children's Court is satisfied that a child meets the highest threshold of being *at substantial and immediate risk of causing significant harm to himself or others, with no other way to manage that risk and ensure that he receives the care that he needs.*"[130]

The secure care facility was not to be used for punitive purposes, or as an alternative to providing psychiatric care, but rather, "*the aim of a secure care admission is to stabilise young people and keep them safe while developing a suitable plan to address their needs and return to the community. A multi-agency response can assess complex needs and ensure that transition plans are developed and services provided to support the child's return to a suitable placement.*" As an option of "last resort" a young person was to be kept in secure care for "*the shortest [period] necessary to stabilise the child*", with the Bill allowing for a secure care period of up to 21 days, with a further 21 days possible in "exceptional" circumstances.[131] The aim, according to the Explanatory Memorandum, was to "*ensure children are protected from prolonged periods of time kept under a secure care arrangement.*"[132]

The Explanatory Memorandum also described that the Amended Act sought to ensure the principle of child participation in decision making would apply to children under a secure care arrangement by making clear that decisions about secure care arrangements were among those decisions likely to have a significant impact on a child's life.

As in the Second Reading speech, the Explanatory Memorandum stressed that "children are placed in the secure care facility as a measure of last resort only, once it has been determined that there are no other suitable ways to manage the situation", furthermore, that a "secure care arrangement is a therapeutic rather than punitive option".

This was a matter of some contention at the time, as seen in parliamentary debate where the then Attorney General, Christian Porter, reiterated the point:

Ms J.M. FREEMAN: But it is very clear that secure facilities are not supposed to be another form of prison, for want of a better word, or mental institution, or any of those sorts of things.

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[129] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr M.P. Whitely, p6962b-6991a, p6

[130] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr A. J. Simpson, p6962b-6991a

[131] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr A. J. Simpson, p6962b-6991a

[132] Explanatory Memorandum, Children and Community Services Amendment, 2010 (Western Australia). p.5.

Mr C.C. Porter: No; indeed.[133]

As part of the Amendment Bill's debate, the Parliamentary Secretary set out the rationale for establishing secure care:

> *These facilities need to be available if an unusual situation happens and a child needs to be in a safe place for his or her own safety to give the facility the time to address the child's needs, take a breather and settle the person down, and look at why the person ended up in that situation… While the child is in a secure-care facility is an opportune time to address and assess the needs of the child. The best way to facilitate that and to take the child out of harm's way and stop him harming himself is to put him in secure care.*[134]

Legislative Requirements

The KFSCC was established under amendments to the *Children and Community Services Amendment Act 2010* (the Act), which came effect on 1 January 2011. These amendments were to address the needs of a small but increasing proportion of children aged 12 – 17 years in the CEO's care who present a substantial risk to themselves and/or others, and require immediate stabilisation, assessment and support.

The majority of the secure care provisions can be found in sections 88A to 88J of the Act and include the threshold for admission to secure care; how children may be admitted; the length of time they may stay; and the planning requirements while in secure care. The Act also provides safeguards which:

- require court orders for children under the provisional protection and care of the CEO;
- enable applications to be made to the State Administrative Tribunal for a review of the secure care arrangements of children who are in the CEO's care under a protection order (time limited) or protection order (until 18); and,
- allow for the appointment of an Assessor with powers which include being able to enter and inspect the facility and talk to children in the facility (see section 125A).

Further fundamentals of the WA secure care model outlined in the legislation include:

Only the CEO of the Department of Communities can initiate a child's admission to secure care, either through direct admission to the facility or by making an application to the Children's Court. In order to do so the CEO must be satisfied that the following criteria, from section 88C of the Act, are met:

(a) there is an immediate and substantial risk of the child causing significant harm to him or herself or another person; and
(b) there is no other suitable way to manage that risk and to support the child to receive the care he or she needs

A child or young person admitted to the KFSCC under a secure care arrangement will be either:

- the subject of a protection order (time-limited) or protection order (until 18) (referred to as a protected child); or

[133] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, p6962b-6991a, p12

[134] Western Australia, Parliamentary Debates, Legislative Assembly, 21 September 2010, Mr A. J. Simpson, p6962b-6991a, p13.

- in the provisional protection and care of the CEO and either already the subject of a protection order or to become one within two working days of the admission.

A child or young person may be admitted to the KFSCC under a secure care arrangement via an:

- Administrative admission, which occurs for a protection child, or a
- Judicial admission, which describes the process required for a child or young person who is in, or is taken into, provisional protection and care.

An interim order (secure care) is an order from the Court that the CEO either make a secure care arrangement for a provisionally protected child, or continue a secure care arrangement that the CEO has already made for the child (referred to as a continuation order). The Court must not make an interim order (secure care) unless the Court is satisfied that there is an immediate and substantial risk of the child causing significant harm to the child or another person; and there is no other suitable way to manage that risk and to ensure that the child receives the care the child needs. Application to the Court for a continuation order must be made by the CEO as soon as practicable and not more than two working days after the child is admitted to the KFSCC.

Under section 88F, soon as practicable after making a secure care arrangement in respect of a protected child, the CEO must decide the period (the secure care period) for which the child is to be kept in a secure care facility under the arrangement. The secure care period must not exceed 21 days unless it is extended under subsection (3) where the CEO may extend the secure care period by not more than 21 days if they are satisfied that there are exceptional reasons for doing so. The secure care period cannot be extended more than once.

A protected child or young person under a secure care arrangement may seek a "reconsideration" of the CEO's secure care decision as to the decision to make the arrangement, the duration of the period of the arrangement or a decision to extend the period, under section 88G of the Act. They will be assisted to comply with the requirement for a written application, as required. The child's parents / carers or any other person considered by the CEO to be significant in the child's life, may also apply for a reconsideration of a secure care decision. A "secure care decision" is the secure care arrangement, which is the decision to admit a young person to the secure care facility; the secure care period; any extension of the secure care period. The CEO may then confirm, vary or reverse the previous decision.

In the event that a young person or other applicant is not satisfied with the outcome of the CEO's reconsideration, he or she may apply to the State Administrative Tribunal for a review of that decision.

Under section 88F the CEO may extend the secure care period by not more than 21 days if the CEO is satisfied that there are exceptional reasons for doing so.

Section 88I (5) outlines the requirements for a care plan or provisional care plan for a child in secure care. These plans must identify the needs of the child in his or her transition to other living arrangements after leaving the secure care facility; and outline steps or measures designed to address those needs and to reduce the likelihood of the child being placed in a secure care facility again.

Under section 125A of the legislation the CEO may, in writing, appoint a person to be an assessor if the CEO is satisfied that the person has the experience, skills, attributes or qualifications the CEO considers appropriate to enable the person to effectively exercise the following powers: at any time, visit a facility

and do one or more of the following : enter and inspect the facility; inquire into the operation and management of the facility; inquire into the wellbeing of any child in the facility; see and talk with any child in the facility; inspect any document relating to the facility or to any child in the facility. An assessor must provide a written report to the CEO about each visit made by the assessor.

Staffing

KFSCC has a multi-disciplinary, coordinated team approach including a Senior Clinical Psychologist, Senior Child Protection Worker, Senior Secure Care Officers and Secure Care Officers, GP and Nurse. The Secure Care leadership group consists of an Assistant Director and Director who manage the day-to-day operations of Secure Care, as well as develop and contribute to policies and programs directly affecting their unit.

Staff are required to undergo training that provides them with skills and knowledge to offer high quality therapeutic interventions for children and to understand the effects of trauma and abuse on brain development that results in challenging and confrontational behaviour. Secure Care Officers are described as caring for and engaging with the children to assist them to work within the individual program developed for each child. Secure Care Officers Training includes therapeutic crisis intervention, which provides knowledge and strategies to avoid behavioural escalations from children whose behaviour can often be volatile, as well as the capacity to take physical control as an ultimate safety measure to prevent children from harming themselves or others.

It is documented that Senior Secure Care Officers oversee the interactions that Secure Care Officers have with children, and are a critical part of the assessment of children entering care, and developing and implementing their therapeutic and safety plans. They also work directly with children, where they provide a high standard of trauma informed therapeutic care. The therapeutic approach and organisational culture at the KFSCC is underpinned by the Sanctuary model – a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology. Senior Secure Care Officers are expected to ensure the principles of Sanctuary[135] are embedded in practice, and that practice meets the requirements of the *Children and Community Services Act 2004.*

Service Model

Documentation states that KFSCC offers a planned, short-term intensive trauma informed intervention for children and young people aged 12-17 years of age. In exceptional cases children under 12 years of age who are at extreme risk and where existing services cannot manage the risk can be admitted to the Centre. The KFSCC practice is guided by the Sanctuary Model. The Sanctuary Model aims to create an organisational environment in which there is an understanding of the impact of trauma on individuals and families. This knowledge is embedded in all policy and procedures and interventions. The Sanctuary Model aims to develop an organisational culture that:

- recognises children have suffered a variety of traumatic experiences;

[135] The culture and operational philosophy of the therapeutic care services of the Department of Communities, including the KFSCC, is underpinned by the Sanctuary Model® and principles.

- encourages staff to teach important skills, but also model those skills in their interactions with children;
- develops a common understanding of the reasons behind behaviour, rather than simply responding to the behaviour itself;
- provides extensive training to develop common understandings of children's challenges;
- emphasises the importance of shared goals and the creation of a philosophical framework in which these goals can be achieved;
- utilises conflict resolution strategies to support a non-crisis based and non-reactive service of care; and,
- engages staff in continual reflective practice.[136]

Trauma Informed Organisational Culture

The Sanctuary Model emphasises seven dominant cultural characteristics required to develop an organisational culture that is committed to addressing trauma. These are:

- non-violence: building safety skills;
- emotional intelligence: helping to teach effective management skills;
- inquiry and social learning: building cognitive skills;
- shared ownership: helping to develop skills of self-control, self-discipline, and the administration of healthy authority;
- open communication: helping to overcome barriers towards healthy communication, the reduction of 'acting -out' behaviours, the improvement of self -protection and self-correcting skills, and the creation of healthy boundaries;
- social responsibility: rebuilding social connections, establishing healthy attachment relationships;
- growth and change: restoring hope, meaning, and purpose to empower positive change.

Recovery Approach

The Sanctuary Model provides the S.E.L.F. framework - a trauma-informed tool to help staff and children and young people move through four critical stages of recovery. It incorporates the following elements:

S Safety: Attaining safety for oneself, for others and the creation of a safe environment overall

E Emotions: Examining personal experiences and developing impact management skills

L Loss: Feeling grief and dealing with personal loss

F Future: Bettering future outcomes by trying out new roles and practicing ways of relating in order to ensure personal safety and to help others.

Central to the effectiveness of the Sanctuary Model is the importance of evaluation in order to demonstrate an organisation's ability (or inability) to make positive changes.

136 Bloom, S. L. (2013). The Sanctuary Model. Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models, 277-294.

Nine indicators are utilised to guide the evaluation of progress:

1. Less violence (physical, verbal and emotional)
2. A greater understanding of the impact of trauma within the system;
3. Less victim blaming, including fewer punitive or judgemental responses to behaviour;
4. Clearer and more consistent boundaries with higher expectations (linked to rights and responsibilities);
5. Earlier identification of perpetrator behaviour, plus appropriate strategies to deal with this;
6. Enhanced ability to state clear goals, create strategies for change, and to justify the need for a holistic approach;
7. Better understanding of repeat behaviours and resistance to change;
8. A more democratic environment at all levels;
9. Better overall outcomes for children and young people, staff, and the organisation.[137]

Comparing Secure Care Programs

Along with Western Australia, New South Wales and Victoria, have secure care facilities for children under child protection orders. The aims of all the secure care facilities are containment and safety assessment and provision of a therapeutic environment with differing implementation models applied to achieve these aims[138]. In all three jurisdictions the point of intervention at which a child is referred to secure care involves children considered at extreme risk. The admission criteria and point of intervention is not for children requiring a mental health facility or who need containment on the basis of a criminal activity and thus a juvenile justice response. One critical difference is that unlike Victoria and Western Australia the admission of children to secure care is not provided for in legislation in NSW.

Some of the differences between WA, NSW and Victoria relate to the models of care and therapeutic framework utilised, philosophies of care, staffing arrangements and care team compositions, the contributions provided by different professional and service streams, the training provided to staff (such as attachment, trauma informed, or neuro-physiologically informed), the degree to which models of care are informed by evidence, and the quality or source of that evidence, and extent of involvement of other government services and agencies and private sectors organisations. There are also variations in the way that placement in secure care is initiated, oversight of the placement, the length of time that a child can remain in secure care and the review and reporting requirements. There is limited evidence available demonstrating the effectiveness of any of these facilities.

The following seeks to compare and explore further the components of secure care facilities and approaches in NSW, Victoria and WA. For further details and comparisons between the jurisdictions, refer to Annexure C (Australian context).

Criteria

[137] Bloom, S. L. (2005) The Sanctuary Model of Organizational Change for Children's Residential treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations. 26(1): 65-81.
[138] Mercy Community Services (2016), Secure Care Submission, Queensland.

Currently, across all the jurisdictions with secure care facilities in Australia, there is a clear distinction between secure care and youth detention, with admission criteria that excludes the admission of children via a court decision on criminal charges. Application for a child's placement in secure care is based on an identified substantial and significant risk to the child where such an intensive level of protection is deemed the only suitable option for ensuring their safety and wellbeing. Placement in a secure care facility generally involves containment and a restriction of a child's or young person's liberty. The intended age of children admitted to secure care range from between 12 and 17 years in NSW, 10 to 17 years in Victoria, and 12 to 17 years in Western Australia. In Western Australia and Victoria, the intended ages for secure care are not provided in the legislation, rather a matter of Department policy. All three jurisdictions have admitted children younger than 12 into secure care.

In Victoria and Western Australia there are legislative requirements and criteria that ensure placement of a child in secure care is only utilised as an option of last resort where all other placement and support options have been considered and cannot provide the child with adequate protection from significant harm or reduce the risks to or posed by the child. In NSW secure care is not legislated, it is via a Supreme Court order made by the Director of FaCS. In NSW, Victoria and Western Australia secure care is utilised in a welfare context, not a juvenile justice context. In Western Australia secure care is not punitive detention and the criminal justice jurisdiction does not have the power to make a secure care arrangement for a child. The Department of Communities' Policy Document on children entering secure care states that it is inappropriate for secure care to be used as an alternative option for children remanded in custody or serving a period of detention. In New South Wales children who are eligible for involuntary treatment under the *Mental Health Act 2007* may be admitted to therapeutic secure care for a short duration if necessary. The program guidelines also state that children with a significant, complex mental health condition who require close psychiatric monitoring and treatment must be carefully assessed when placement in therapeutic secure care is being considered and, if admitted, their treatment is to be provided by health professionals.

Placement Authority and Length of Stay

In New South Wales the Supreme Court has responsibility for determining whether or not a 'therapeutic secure care order' is made which are subsequently approved by the Deputy Chief Executive, Department Family and Community Services. The Supreme Court makes interim therapeutic secure care orders only, sets review dates and issues instructions to the Department about the information to be provided at the next review. A seven-day order is usually initially obtained to allow for adequate assessment of the child and to make further application to the Supreme Court. If satisfied, the Court then grants a three-month order. Orders are reviewed every three months by application to the Supreme Court. Further applications to the Court must be made every three months to satisfy the Court that the criteria for secure care continue to be relevant. The average length of stay in secure care in NSW is between 16 – 24 months.

In Victoria for children already under an Order, the Secretary of the Department of Human Services approves an application if they are satisfied that there is substantial and immediate risk of harm. As with WA, there must be court application/order if the child is not already in the care of the CEO.

Victoria and Western Australia have similar models of secure care in which a secure care arrangement may be made for up to a maximum of 21 days (the secure care period). The secure care period can be extended, once only, by not more than 21 days. This does not mean that there cannot be subsequent placements of a child in a secure care facility. The purpose of secure care in both states is designed to be an emergency/short-term option where the containment of a child is designed to reduce the child's risk of harm, be strictly time-limited and used to develop or revise the plans for the child's return to the community including referral to other longer-term therapeutic programs, placement and support services

Review Procedures

All Australian jurisdictions providing secure care have appeal and review processes in place. In New South Wales, these are judicially based. In Victoria persons affected by an administrative decision to place a child in n secure care (i.e. a parent, carer or child) may first request an 'internal' review – a "reconsideration" in WA. Decisions that can be reviewed include the decision to make a secure care arrangement for the child, length of the secure care period or the or the decision to extend the secure care period by not more than 21 days if there are exceptional reasons for doing so. In certain circumstances, parties within Victoria may have casework decisions reviewed by the Victorian Civil and Administrative Tribunal and in Western Australian parties to administrative admissions may similarly access the State Administrative Tribunal if they wish to have the outcome of the internal reconsideration reviewed.

Oversight and Reporting

Mechanisms for overseeing the activities of secure care facilities include monitoring through oversight reporting and complaints mechanisms, community visitor programs and process evaluation strategies such as child/youth satisfaction surveys. Oversight arrangements in Victoria and Western Australia vary.

In Western Australia, the role of Assessors was part of the initial suite of secure care provisions and were for the purpose of providing oversight for secure care facilities and residential facilities as defined in the Act.

As described in the CCSA 2004 section 125A (3), 'An assessor may, at any time, visit a facility and do one or more of the following:

(a) Enter and inspect the facility;
(b) Inquire into the operation and management of the facility;
(c) Inquire into the wellbeing of any child in the facility;
(d) See and talk with any child in the facility
(e) Inspect any document relating to the facility or to any child in the facility'.
(4A) A child in a facility, or a parent or other relative of a child in a facility, may request the person in charge of the facility to arrange for an assessor to visit the facility and see and talk with the child.

(4) An assessor must provide a written report to the CEO about each visit made by the assessor under this section.'

Communities' practice with regard to the Assessor process involves the following:

- The first stage is a comprehensive assessment and review of the facility as described in the Act. The second stage involves the assessment and review of the implementation of the recommendations generated from the initial visit and report.
- Three months after completion of the Initial Visit Final Report the designated Follow-Up Visit Assessor will visit the facility to determine if the recommendations have been completed. The Final Report: Follow Up Visit is provided to the Department's Director General. Copies of the report are forwarded to KFSCC Management and a redacted copy of the report is provided to the Commissioner for Children & Young People.

As at April 2018, nine Assessor Reports were provided to the Evaluation. Annexure E of the Literature Review provides a summary of each Assessor Report against each of the following:

- Issues of note
- Recommendations and/or required actions and
- Status of responses to recommendations and/or required actions, if and when noted in subsequent follow-up Assessor reports.

By way of example, provided below is a selection of recommendations arising from a sample of Reviews:

- Review children's admission processes to ensure physical environment is safe.
- Transportation framework & risk management plan for transporting children from regional areas.
- Increase utilisation of statistics collected to monitor and develop programs.
- Additional strategies for increasing collaboration between health team, district staff and external health providers to support child beyond their stay at KFSCC.
- Case note template to be improved to enhance measurement of outcomes.
- Improve quality assurance processes for documents relating to decisions about SC periods of stay and extensions.
- Consider oversight arrangements for referral assessment process.
- Improve development, definition and measurement of secure care goals.

An overview of the status of completion of a selection of recommendations arising from reviews is provided is provided in Annexure E.

In Western Australia, section 125A provides that assessors may, at any time, enter and inspect the facility. However, the assessors were not intended as advocates, their role, as provided in section 125A, is to provide systems oversight. Victoria does have scheduled visits from their respective Commissioner for Children and Young People and Ombudsman's office and requires review/assessor reports to be provided to their Children's Commissioner. In March 2016, amendments to the *Commission for Children and Young People Act 2012* (VIC) came into effect that require the Secretary to the DHHS to disclose to the Children's Commissioner "any information about an adverse event relating to a child in out-of-home care or a person detained in a youth justice centre or a youth residential centre if the information is relevant to the Commission's functions." In NSW, the Office of the Children's Guardian must receive written notification every time a child under 12 years of age is placed in residential statutory out-of-home care including the state's secure care facility. Records of practice relevant to the safety, welfare and wellbeing of children

and young people at Sherwood House must also be made available to the Children's Guardian for inspection upon request, in written form or an electronic format.[139]

Staffing and Case Management

There are differences among the jurisdictions in terms of the staffing structure within secure care facilities. Some have clinical specialists working full-time or part-time alongside other trained staff. In other centres, all staff members receive training in trauma-informed care, and residential psychologists are available to support staff in providing care. The amount and type of specific training offered to staff also varies to some degree across the jurisdictions. Some offer induction training in trauma-informed care and access to ongoing training in areas such as child development, brain development and the effects of trauma, and therapeutic crisis intervention.

In NSW the therapeutic secure care program is managed and operated directly by the DFaCS (Operations) under the direction of the Director, Intensive Support Services (ISS). The ISS unit includes the secure care facility and an intensive case management team where children with the most complex needs and high-risk levels across the state are intensively case managed by highly skilled caseworkers who have a maximum caseload of six. An independent Clinical Director is appointed to oversee the therapeutic aspects of the program and ensure independent clinical advice. All children and young people in this program have a department caseworker from the ISS team. The clinical program design, client case formulation, behaviour support planning and staff training at Sherwood House are contracted through a private agency (fee for service). The carers in the program are contracted from non-government personnel management agencies working in the youth work sector. While staff members are contracted from agencies, they work at Sherwood House as permanently rostered staff. Sherwood House is staffed during the day by four carers, one House Manager and one Manager and one carer during the night shift. The centre also employs four security staff per shift who have a 'watching brief' or line of sight role with the aim of providing rapid de-escalation by firstly escorting the child away or if necessary, the use of a sitting or standing restraint. Sherwood house do not utilise seclusion with critical incidents (there is no safe room in Sherwood House[140]

In Western Australia secure care is staffed during the day by one Senior Secure Care Officer and five Secure Care Officers. Night shift staffing consists of one Senior Secure Care officer and two Secure Care Officers. Staff Qualifications are Certificate III and Certificate IV in a Human Services discipline (such as Children's Services) or allied field of study, or an outline of equivalent experience in working with or caring for traumatised and abused children. The primary role of Secure Care Officers is to provide safety through therapeutic interventions and relationships, as well as trauma informed practice. They provide crisis co-regulation as well as physical containment for children who are at extreme risk of harming self and/or

[139] Office of the Children's Guardian, NSW. Notice of Conditions of Accreditation as a Designated Agency. Community Services Sherwood House. Issued under Clause 65 of the Children and Young Persons (Care and Protection) Regulation 2012.
140 Personal communication with Assistant Director, ISS, FACS, NSW.

others. This is under the guidance of Therapeutic Crisis Intervention practice, with physical intervention being a last resort.

The centre's Director, Assistant Director, Senior Clinical Psychologist and Medical Practitioner and Senior Child Protection Worker attend children's initial planning meeting; progress meeting and exit meeting along with the district care team (Case Manager, Team Leader, District Director, Assistant District Director, District Psychologist, and Aboriginal Practice Leader) and any relevant external agencies. The Centre's Senior Clinical Psychologist produces a Discharge Summary at the child's point of exit.

Victoria's Secure Welfare Services

Given the similarities between the secure care models of Western Australia and Victoria, it is worth exploring the Victorian system in more detail. The *Children, Youth and Families Act 2005* consolidated and replaced the *Children and Young Persons Act 1989* and *Community Services Act 1970,* and its provisions came into effect on 23 April 2007. As with its predecessor the 2005 Act defines a secure welfare service as a "community service that has lock-up facilities"[141] The Act sets out that the Secretary (to the Department of Health and Human Services) may deal with a child in a number of ways, including by placing:

> *him or her in a secure welfare service for a period not exceeding 21 days (and, in exceptional circumstances, for one further period not exceeding 21 days) if the Secretary is satisfied that there is a substantial and immediate risk of harm to the child.*[142]

Section 75 of the Act states that if a child is placed in a secure welfare service the Secretary is required to plan for, and support, the transfer of the child to, and integration of the child in, another suitable placement to reduce the likelihood of the child being placed in a secure welfare service again. In Victoria secure care is currently provided through two 10 bed gender specific secure facilities. The facilities are overseen by the Department of Health and Human Services.[143]

Children aged 10 to 17 years subject to a family reunification order, a care by Secretary order or a long-term care order may be placed in secure welfare services subject to approval of the area operations manager or assistant director, child protection or a more senior officer. In exceptional circumstances children under the age of 10 years may be admitted to a secure welfare service subject to the approval of the area director, or director, child protection in the child's division. There are two avenues through which children can be placed in Secure Welfare Services (SWS). If a young person is not on a protective order, they are admitted through a Children's Court Interim Accommodation Order in a secure welfare service. A child taken into emergency care may be placed in a secure welfare service, if there is substantiated and

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141 Children, Youth and Families Act 2005, (Vic) Act No. 96/2005, p15

142 Children, Youth and Families Act 2005 (Vic), s173, p.110 [emphasis added]

143 Consultation with the DHHS confirmed that the exact date of secure welfare services as they currently exist is difficult to determine as the current facilities have existed prior to the current arrangements and were previously used for the containment of at risk children and young people in both a youth justice and welfare context. The Ascot Vale facility has been in existence since the mid-1990s and the Maribyrnong facility was built in 2002. The facilities are said to have "gradually" transitioned to their current provision of care.

immediate risk of harm to the child, until the matter is bought before the court or a bail justice. The SWS is responsible for the day-to-day protection and care responsibilities for children placed there.[144]

Placement at a Secure Welfare Service:

- occurs only if no other less restrictive action is sufficient to protect the child
- is for the minimum period necessary within legally prescribed timeframes
- requires assertive intervention and case planning following placement to address the protection needs of the child and plan their exit
- is reviewable.[145]

There is rarely one isolated factor for a placement in SWS. 'Risk of harm' is the essential placement criteria, however what this encompasses is not defined in legislation except for the fact 'the assessment of risk may be made on the basis of a single incident or an accumulated risk' (s. 173 [3]) and that 'accommodation is not by itself a sufficient reason for placing the child in a secure welfare service' (s.174 [1 (c)). There are also provisions for the placement and exit of Aboriginal children in SWS that require consultation with the Aboriginal Child Specialist Advice Support Service.

Legislative Changes

In 2013, the Victorian Ombudsman conducted an investigation into the state's Secure Welfare Services. This followed a number of allegations raising concerns about the treatment of children in these facilities.

The Ombudsman noted that secure welfare is 'the most extreme form of child protection' and suggested 'it is important that secure welfare is administered to the highest standards'. The investigation identified concerns with aspects of how the overseeing department was managing secure welfare, including

- children being subjected to searches, akin to prohibited strip searches, and physical restraint without a legislative basis
- children being placed in isolation without a legislative basis here being no independent visitor program for secure welfare as there is at adult prisons and youth justice centres
- poor record keeping which meant that a number of authorities for admission were not signed and there was no accurate data recording the use of restraint and isolation
- secure welfare being often at or near capacity with staff expressing concern that placement decisions were based on capacity rather than need.

The Ombudsman's report (2014) made eight recommendations, all of which were accepted by the department. Nonetheless, she suggested there that areas of concern remained with regard to secure welfare and noted that she would continue to monitor the situation.[146]

[144] Victoria, Health and Human Services, http://www.cpmanual.vic.gov.au/policies-and-procedures/out-home-care/secure-welfare/secure-welfare-service-placement

[145] Victoria, Health and Human Services, http://www.cpmanual.vic.gov.au/policies-and-procedures/out-home-care/secure-welfare/secure-welfare-service-placement

[146] Ombudsman Victoria, Annual Report 2013 – Part 1 (Melbourne: Ombudsman Victoria, 2014), p.44-45

Following the Ombudsman's investigation, the Children, Youth and Families Amendment (Security Measures) Bill 2013 was introduced. This Bill sought to provide for a legislative framework to largely codify existing practices in Victoria's secure welfare services. The Bill's explanatory memorandum suggested:

> *The main purpose of the Bill is to amend the Children, Youth and Families Act 2005 to provide for security arrangements for secure welfare services, to prohibit certain actions in relation to children placed in an out of home care service, and to make amendments in relation to the searches permitted in youth justice facilities.*[147]

While the Bill passed with bipartisan support, then opposition spokesperson Jenny Mikakos expressed concern that with the passing of the Bill, "vulnerable children in the state's care may be further harmed by practices including search, seclusion and physical force" in evidence on the state's secure facilities.[148]

Reflecting wider reforms in the child welfare sector, in October 2014 *The Age* reported that young people in secure welfare facilities would also be required to attend educational activities for up to six hours a day under a government plan to re-engage them in education in a bid to get their lives back on track."[149]. A specialist provider (Parkville College) was contracted in 2014 to provide onsite lessons in literacy, numeracy, hospitality, sport and music.

Reviews and evaluations of Secure Welfare Services

In her analysis of Victoria's Secure Welfare Services Crowe (2016) notes "the significant absence of data and information on SWS" and that there has been no external and publicly available SWS evaluation, cost–benefit analysis or evidence basis specifically relating to SWS. She also notes publicly available information about SWS is minimal, and the practice "very rarely receives more than a passing reference in media".[150] Material relating to SWS is generally limited to legislation and associated parliamentary discussion, passing references in reviews and inquiries and reports. [151]

Since 2009, the Victorian Ombudsman has conducted three inquiries pertaining to child protection. The inquiries have included those related to out-of-home care, child protection services in general and child protection service delivery issues in specific localities of the state.[152] There have also been audits undertaken by the Victorian Auditor-General: one relating to residential care services for Victorian children, and two relating to service access for vulnerable people. Common themes evident in the audit

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[147] Explanatory Memorandum Children, Youth and Families Amendment (Security Measures) Bill, 2013,

[148] Jenny Mikakaos MP, http://www.jennymikakos.com.au/parliament/children-youth-and-families-amendment-security-measures-bill-2013

[149] Farrah Tomazin, 'Victoria's most vulnerable youth to get new education program' The Age, 5 October 2014

[150] Crowe, K. (2016). Secure Welfare Services: Risk, Security and Rights of Vulnerable Young People in Victoria, Australia. Youth Justice, 16(3), 263-279, p.265.

[151] Communication with representatives of Victoria Secure Welfare Services confirmed there has been no evaluation of SWS, although there is currently an internal review examining aspects of the service including potential therapeutic models of care.

[152] Ombudsman Victoria, Own motion investigation into the Department of Human Services child protection program (Melbourne: Ombudsman Victoria, 2009). Ombudsman Victoria, Own motion investigation into child protection – out of home care (Melbourne: Ombudsman Victoria, 2010). Ombudsman Victoria, Investigation regarding the Department of Human Services child protection program (Loddon Mallee Region) (Melbourne: Ombudsman Victoria, 2011).

reports are poor oversight by the Department in provision of services, lack of program compliance and accountability, and poor outcomes for service users.[153]

In 2011, the Victorian Government announced the *Protecting Victoria's Vulnerable Children Inquiry* that was tasked with investigating systemic problems in Victoria's child protection system and making recommendations to strengthen and improve the protection and support of vulnerable young Victorians. The three volume report of the Inquiry was tabled in Parliament on 28 February 2012. The Inquiry received 225 written submissions. These highlight a broad range of issues and concerns with the Victorian child protection system including the complexity of cases; the difficulty of meeting the requirements of children with multiple needs and the effect of cumulative harm on children; and, the need for multidisciplinary approaches to serving the complex needs of vulnerable children and families. Many submissions argued for broader availability of a deeper range of therapeutic and support services and placement types with concerns expressed about a lack of enough placements available to appropriately match children and young people and provide a quality, tailored response to meet a child's needs. Significant concerns were also raised about the accountability and quality of residential care facilities; the poorer educational outcomes of children in OoHC and the need for more diverse and flexible education systems that can support vulnerable young people to remain engaged or re-engaged in their learning. Other submissions noted that a lack of public performance measures for service delivery about statutory child protection services impedes public trust and confidence in the system for protecting children. Submissions also highlighted challenges faced by the OoHC workforce. These included the difficulties encountered by regional child protection practitioners in covering large regional or rural areas where specialist and other services are scarce; and the impact of this on attempts to keep a child connected with their community when assessments or treatments are required that are not readily available in particular areas.[154]

The Inquiry also commissioned the CREATE Foundation to undertake research with young people to explore their OoHC experiences. Of note in the report detailing the findings from this research (conducted through focus groups and a customised online survey) is the number of comments from young people about the detrimental effect of living in residential OoHC with other young people with more complex or higher support needs than their own. The report notes that responses highlighted the difficulty of having numerous young people in one placement, all with individual histories of abuse and trauma. The report suggests that

> *"Placements in residential care needs to be made with consideration of the child or young person's strengths and needs, individual abuse and trauma history, culture and developmental needs as well as the needs of other young people already residing with the service. Although the intention is that the placement is a response to each child's physical, social and emotional needs, comprehensive assessment and matching is needed to ensure that each child will not be further traumatised or harmed by the experience."*[155]

[153] There is no substantial references or details regarding the SWS in the associated document of these audits and inquiries.

[154] Protecting Victoria's Vulnerable Children Inquiry, Cummins, P. D., Scott, D., & Scales, B. (2012). Report of the Protecting Victoria's Vulnerable Children Inquiry. Melbourne: Victorian Government Printer.

[155] CREATE Foundation. Final Report: Protecting Victoria's Vulnerable Children Inquiry. August 2011, p.32.

The Victorian Auditor General's report (2016) *Follow Up of Residential Care Services for Children* notes that in October 2014, the Department of Health and Human Services engaged KPMG and the Australian Childhood Foundation to develop an evidence paper based on analysing the case files of 30 children who were frequent users of the department's Secure Welfare Services during 2013–15; a literature review of therapeutic care for children in OOHC; and, a review of the current OOHC options in Victoria. It notes that the evidence paper identified the need for a service response that sits between the short-term Secure Welfare Services response and the longer-term therapeutic residential care service that can focus on stabilising a young person's situation enough to enable them to transition to a stable therapeutic placement option. A 'contained therapeutic model of care' was proposed, which aimed at supporting this small cohort of young people whose complex needs are not being adequately met by the OOHC system and who cannot remain in SWS. The report notes at the time of writing the department had received the draft final report outlining model options for a contained therapeutic model of care and was considering these options in the context of the *Roadmap for Reform: strong families; safe children*.[156]

In 2009, Verso Consulting was commissioned to undertake an evaluation of Victoria's Therapeutic Residential Care (TRC) pilots, which were intended as a part of Victoria's Out-of-home Care (OoHC) system for children and young people. In June 2007 the then Victorian Department of Human Services (DHS) launched the first TRC pilot, referred to as Hurstbridge Farm. Development of the TRC program was driven by demand, concern about outcomes from existing models, the increasing complexity of the children and young people utilising the service, and ongoing concern about service costs. The provision of Sanctuary training to residential care staff was tested at the Hurstbridge Farm, and results from this evaluation encouraged DHS to expand delivery of the TRC programs to a further 11 pilot sites across Victoria, each with a specific client focus.[157]

The evaluation commenced in August 2009 and concluded in July 2011, with the aim of providing advice to DHS regarding the effectiveness and efficiency of providing a specialised therapeutic residential setting for children and young people experiencing the aftermath of trauma and neglect. Amongst the findings detailed in the final Summary and Technical Report (2011) it was noted that the practice of Therapeutic Residential Care leads to better outcomes for children and young people in comparison to standard residential care practice. These outcomes included: an increased community connection, significant improvements to sense of self, increased healthy lifestyle choices and reduced risk taking, enhanced mental and emotional health, and improved physical health.

The impact of Therapeutic Residential Care on Secure Welfare Services Admissions

Of particular note in the evaluation of the TRC pilot sites was the impact on secure welfare services admissions. It found that a reduction in risk taking by children and young people in the TRC pilot sites had a direct impact on SWS admissions. The report notes that Secure Welfare admissions for

[156] Victorian Auditor-General's Report Follow up of Residential Care Services for Children. (Melbourne, Victorian Auditor General, June 2016).

[157] Verso Consulting Pty Ltd., (2011) Evaluation of the Therapeutic Residential Care Pilot Programs, Final Summary and Technical Report, Department of Human Services.

the TRC population dropped from a median of 16 at TRC entry to 3 at 18-21 months post-entry and down to 0 at 24-27 months. The report suggests that the use of TRC can reduce immediate costs to government by reducing police time, use of expensive secure welfare placements, the frequency of hospital admissions and other use of other community services. The VERSO report concluded that "Therapeutic residential care practice leads to better outcomes for children and young people than standard residential care practice."[158] It noted that Therapeutic Residential Care was more expensive than general residential care, however the immediate, medium-term, and long-term benefits for children and young people resulted in net benefits from "reduced demand for crisis services and intensive intervention services such as secure welfare, youth justice, policy and the courts." The evaluation determined that there was an avoided cost per child and young person of $44,243.82.[159]

International Comparisons

The following provides some International examples of aspects relating to secure care models. With regard to the latter, as Lambie (2016) states in his examination of New Zealand's secure care models, investigating international models is difficult due to the differing standards and philosophies regarding the purpose of secure care, and the available alternatives to secure care in one's own jurisdiction. However, as he suggests, such information can be useful for the consideration of what elements or aspects of these systems could be implemented to enhance current service provision. Thus the intention is to be able situate Western Australia's secure care model in a broader context.[160]

Many of the models of secure care detailed below utilise secure care on the basis of welfare grounds and also for juvenile justice purposes – meaning that children can be placed in secure care as a result of concerns for their welfare or on the basis of offending.

New Zealand

New Zealand has four secure care facilities – referred to as care and protection secure residences. In total, these residences provide around 50 beds nationally. There are several distinct client types in the care and protection secure residential population: females, child offenders (< 13 years) both with current and previous offences, young care and protection children (≤ 12 years), and those children and young people with significant trauma and neglect histories. For admission into secure care, all children and young people must be under the care, custody or guardianship of the Chief Executive of the Ministry of Social Development. The two most common legal statuses of young people admitted to care and protection secure residences in New Zealand are s101 (custody order) and s78 (custody of child or young person pending determination of proceedings). On admission, the two most common statuses for young people

[158] Ibid, p.4

[159] Ibid, p.6

[160] Lambie, I. (2016) Care and Protection Secure Residences: A report on the international evidence to guide best practice and service delivery. Published May 2016 Ministry of Social Development, Wellington, New Zealand. p.63

were s101 (custody order) and s78 (custody of child or young person pending determination of proceedings) orders. Lambie notes that from 2010 to 2014, 73% of young people admitted to a secure care and protection residence had s101 orders. The average stay in a care and protection secure residence is 136 days, with a downward trend in duration over time.[161]

Scotland

In Scotland all young people in secure care have either been sentenced or remanded through court, or placed through the children's hearings system on care and welfare grounds (defined in section 83(6) Children's Hearings (Scotland) Act 2011). Secure care centres are not youth offender institutions, or prisons, though as noted there are some young people in secure care on remand or serving sentences for serious crimes. When a young person has been found guilty, or pleads guilty, the judge, sheriff or Justice of the Peace will decide what sentence is appropriate. They may defer sentencing for days or weeks, during which the young person may be detained in secure care or custody. Children and young people can be placed in secure care through the Children's Hearings System (the CHS) or the Courts.

Gough (2016) describes the secure care system as part of Scotland's welfare based approach to children and young people who may have been involved in offending behaviour. She notes that where young people have been involved in serious offences and detention is necessary, the aim is to ensure consideration be given to secure care as the place of detention, rather than imprisonment. She also notes that one of the key aims of this welfare based approach is to ensure that wherever possible young people who have been involved in serious offences are diverted from detention including secure care. As a result, there has been a significant reduction in the number of young people in secure care on offence grounds.[162] At present more than 90% of young people who are in secure care in Scotland are there through the CHS, rather than because they have been remanded or sentenced by the Courts. Moodie (2015) notes that in Scotland and also in England and Wales, the majority of female authorisations to secure care are on a welfare context and due to welfare concerns whereas for males these authorisations are more likely to be on offence grounds.[163]

The average age of young people when they are placed in secure care in Scotland is nearly 15 years, with some very rare occasions of children under 12 having been secured. The average length of stay in secure care is between three and four months, but in parts of the secure care sector which proportionally have more young people placed on remand and short term orders, the average time in a secure care placement is nine weeks.

In Scotland oversight functions of secure care units are provided by an independent body – the Care Inspectorate who assess the unit and report against National Health and Social Care Standards. These

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[161] Lambie, I. (2016) Care and Protection Secure Residences: A report on the international evidence to guide best practice and service delivery. Published May 2016 Ministry of Social Development, Wellington, New Zealand

[162] Gough, A. (2016), Secure Care in Scotland: Looking Ahead. Key messages and call for action. Secure Care National Project, Centre for Youth and Criminal Justice. October 2016.

[163] Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice.

reports are made publicly available and also grade the effectiveness of secure care units.[164] Similarly, in Ireland the Social Services Inspectorate within the Health, Information and Quality Authority has a statutory function to inspect the statutory children's residential centres including Special Care Units. These inspections are conducted in conjunction with the National Standards for Special Care Units developed by the Department of Health and Children. Further details are provided in Annexure D (Scottish context) of this Literature Review.

USA

Youth Justice and child protection Law and practice varies hugely across States of the USA, so that some States may be described as having far more progressive, psycho-social and child-centred legislative, policy and practice frameworks than others, and therefore there are many different models and approaches to the use of restricted care settings or detention and custody for children, young people and young adults.

Examples:

New York City

The Age of Criminal Responsibility (ACR) was raised to 18 in 2017, and under 18s are dealt with in the Children and Youth systems rather than the adult Justice System. Since the changes in ACR, Youth Justice was transferred to the New York City administration for children's services, which could be regarded as the equivalent of a local authority children's services department (in the UK.) There is a 'close to home' initiative, so that children are placed in therapeutic children's homes close to their communities rather than 'correctional' facilities, (which are essentially prisons and are miles from the city). Each of these houses looks after 6-20 young people, near the five boroughs of New York. There are regular family visits and work with families is undertaken. Placements last for 6-7 months on average, and there is 4-6 months of aftercare from charity and other support organisations.

Missouri

Young people may remain under joint youth/adult jurisdiction until age 21 years. Missouri historically operated 'training schools' which were based on a reform school/correctional methodology. These were closed in 1980 when there was a radical transformation of the youth justice approach. This led to smaller group homes, camps and treatment facilities being established and prison guards and officers were replaced by child care, and youth development specialists, with an emphasis on constant staff interaction and relational based practice, supervision, guidance and support and reflection in small groups (a therapeutic community type model). The majority of these services care for less than 36 young people and evaluations have indicated positive outcomes; 85% productively engaged in school, college or employment on discharge and 75% made at least one year of academic progress per year in confinement

[164] The Scottish Government established the Secure Care Strategic Board in 2017 whose role includes developing a Secure Care National Standards to improve experiences and outcomes for most vulnerable young people. The Board is due to report by the end of 2018.

(compared with national average of 25%), with evidence of reduced re-offending rates and majority avoiding serious criminal involvement for at least three years post discharge.

Sweden

The age of Criminal Responsibility is 15 years, so all children below 15 who are involved in offending are dealt with by social services. For young people in conflict with the law aged over 15, responsibility is shared between Social Services and Justice Services. The Social services Act 1982 means that children are taken into custody, when they are deemed to be in need of out of family care, so even small children who are in need of care and protection are in law taken into custody. The decision to take a child into custody/care is made by a 'local social welfare board'. Despite the legal framework and definition of 'custody', in reality the young person is usually placed in a family home or a so-called 'home for residence and care'. There is an option for young people aged 15-17 to go to 'secure youth care' instead of prison, and within these settings there is partnership working between psychology, education and treatment providers.[165]

Canada

Canadian states each have scope within the Canadian legal system for their own provincial law and policy position in relation to use of secure/restricted settings as a response to vulnerable and high risk youth. Depending upon the jurisdiction, secure care facilities are utilised for longer term criminal justice to medium term mental health treatment to shorter term crisis or substance misuse programs. There are seven provinces in Canada that have legislative provisions within their child protection legislation for the involuntary confinement of young people for the use of secure care or treatment. Two provinces have legislation outside of their child protection acts that allows for the confinement of young people misusing substances. In addition, Alberta has specific legislation that permits the confinement of young people who are being sexually exploited. Four other provinces and the three territories – Yukon, Northwest and Nunavut – do not have provisions for the involuntary confinement of children and young people except in their mental health or criminal justice legislation. As an alternative these jurisdictions utilise intensive one-on-one supervision and/or confine the young person in their mental health and/or criminal justice facilities. Grant (2016) suggests that one outcome of these alternative arrangements is young people being labelled criminal or mentally ill in order to access safe and secure environments for them.[166]

Australian Jurisdictions without secure care models

Queensland, South Australia, Tasmania, Northern Territory and the ACT are all jurisdictions without a welfare based secure care model. However, as with all the states and territories, they have significant numbers of highly traumatised children presenting in OoHC with a range of complex needs and challenging behaviours. All jurisdictions have policies and procedures for ensuring children in care's safety

[165] http://www.cycj.org.uk/spot-the-difference-sweden-international-case-study/

[166] Grant, C. (2016) Secure Care Summary Report (Part One): Legislation. Available at: https://www.researchgate.net/publication/308891681_Secure_Care_Summary_Report_Part_One_Legislation

and responding when there is an assessed risk to that safety. Responses may involve placing children a high needs placement, or residential care home. All jurisdictions have forms of Therapeutic Residential Care (TRC) including Victoria and Western Australia, that are regarded as providing options for children and young people with multiple and complex needs. McLean et al., (2011) note that TRC "shares some components of psychiatric hospital/secure treatment unit care, and has many features in common with both treatment and therapeutic foster care."[167]

Generally, TRC is provided to children aged 12 – 17 years with complex or extreme support needs although there are provisions for children younger than 12 years in cases where their needs are deemed to be best met by TRC. One difference however with TRC is the fact that these services cannot 'contain' these children through the use of various security measures. In jurisdictions without secure care provisions, children can only be detained for highly specified purposes enshrined in legislation associated with youth justice, mental health, public health and migration.

[167] McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, Australia, p.3.

Analysis of Key Issues

This section examines the key issues that dominate the available literature on secure care facilities and programs.

Duration of Stay

The duration of a child's stay in secure care appears to be a contentious issue with mixed views regarding the benefits of lengthier stays as is the case in NSW, compared to those that are short and limited to a maximum of up to 21 days, with the option of one extension of up to 21 days, in Victoria and Western Australia. Some suggest that longer placements in a highly structured, restricted and controlled environment such as therapeutic secure care, increase the risk of institutionalisation and should be considered cautiously.[168] Others make the case that there is a lack of research evidence that outcomes for children in secure care for short time periods are positive.[169] Although it is considered in the young person's best interests to not be placed in secure care for longer than strictly necessary, some suggest a lack of time can also mean a failure to work towards positive outcomes within a nurturing secure environment.[170] In 2002 researchers in England tracked the outcomes of a group of adolescent boys in a secure care facility where children are admitted from both a welfare and justice context. On admission there were high rates of aggression, substance misuse, self-harm, social, family, and educational problems and associated needs among the cohort. After three months the areas in which needs were mostly met included education, substance misuse, self-care, and diet, however, the other recorded needs remained high.[171]

In Scotland where there are five secure care units, a young person's stay in secure care is determined by a set criteria which is reviewed on a three monthly basis at a Children's Hearing - with no time limit on the number of three monthly orders that can be given. The Scottish system is designed to enable sufficient time for robust assessments, interventions and transitions to be put in place, as well as an opportunity for services to accurately measure the impact and outcomes of all young people accommodated in secure care. As with Scotland, young people in Ireland are accommodated in secure care on a three-monthly basis. The difference being that Irish law legislates for a maximum period of nine months.[172]

Compared to those facilities working with children for longer timeframes, those working within a 21 day or even 42-day timeframe would have significantly less opportunities for substantive work to be undertaken, as well as minimising the opportunity to measure impact and outcomes. McLean (2016)

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[168] NSW Government Department of Human Services, Out-of-home care service model –Therapeutic Secure Care Programs, May 2012

[169] PeakCare (2013) Secure Care - Needed or Not? PeakCare Discussion Paper, March 2013. Available at: http://c.cld.pw/129/cms/files/SecureCareDiscussionPaperFinal.pdf

[170] Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice.

[171] Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice.

[172] http://www.caab.ie/Functional-Areas/Special-Care/What-is-special-Care.aspx

suggests that for children in secure care "longer term programs that respond to underlying mental health, disability and social needs that emphasise skilled interaction and transition planning hold promise".[173]

Assessment and Intervention Service Provision

Children and young people in secure care have often experienced adverse childhood experiences and have additional mental and emotional health and wellbeing needs. Some may have unrecognised or undiagnosed problems which have been missed. Children and young people's day to day functioning and emotional wellbeing has been compromised by past and ongoing trauma and many require robust and comprehensive assessment accompanied by intensive, well designed and multidisciplinary interventions and specialist services to help and support them to deal with their distress, stress, depression, anxiety and a multitude of behavioural risks.[174]

At the Good Shepherd Centre (GSC) in Scotland a robust assessment process takes place involving a range of professionals utilising the wellbeing indicators from the National 'Getting It Right for Every Child' (GIRFEC) framework. The GIRFEC framework puts wellbeing of children and young people at the heart of its approach. Eight areas of wellbeing are identified, these are the SHANARRI Indicators of; safe, healthy, achieving, nurtured, active, respected, responsible and included (with the addition of Hope by the GSC). These indicators are given context by the four capacities as outlined in a Curriculum for Excellence which aims to ensure that every child and young person be a successful learner, a confident individual, a responsible citizen and an effective contributor. During their assessment young people are also encouraged to take an active part in determining their wellbeing through participation in care, education and health assessments, as well as participation in a subjective online assessment. The online assessment is a programme of self-reporting psychological testing across the GIRFEC wellbeing indicators (with the addition of HOPE) and is an integral part of the overall assessment of a young person's wellbeing, which ensures that the young person's views and opinions of their own wellbeing are placed at the centre of their intervention plans. The robust assessment process is designed to help young people achieve a range of positive wellbeing outcomes during their stay and ensure their personal achievements extend beyond the end of their placement.

In the Scottish secure care sector there has been considerable investment in developing specialist intervention services, where clinicians and qualified health and wellbeing practitioners work together across care, education and support services to ensure that there is a health care pathway, in which the individual needs of each young person are identified, properly assessed and addressed. This happens through treatment and therapeutic interventions, but also through everyone involved with the young person being aware of how to respond to them as an individual in light of their mental and emotional state. In some centres, there are highly effective 'whole system' approaches in place, ensuring that

[173] McLean, S. (2016). Report on secure care models for young people at risk of harm. Report to the SA Child Protection Systems Royal Commission 2016. Australian Centre for Child Protection, University of South Australia, p.8.

[174] Mercy Community Services (2016), Secure Care Submission, Queensland. PeakCare (2013) Secure Care - Needed or Not? PeakCare Discussion Paper, March 2013. Available at: http://c.cld.pw/129/cms/files/SecureCareDiscussionPaperFinal.pdf

attachment and trauma informed thinking underpins all service development, policy review and practice development, including staff supervision, training and support.

The *Healthcare Standards for Children and Young People in Secure Settings* (2013), operating in England and Wales, sets out a pathway and standards for assessment of need, health support and care – across all aspects of physical and mental health and developmental wellbeing for children and young people aged between 10-17 (inclusive) on both welfare and justice placements in secure centres. These standards have been developed by the Royal College of Paediatrics and Child Health, in conjunction with the Royal College of General Practitioners, Royal College of Nursing, Royal College of Psychiatrists, Faculty of Forensic and Legal Medicine and Faculty of Public Health. The standards take a pathway approach, following the young person's journey through a secure setting to aid multi-professional working.

Transitioning

The impact of a secure care stay may be short-term, and although children may improve during the secure care stay, improvement during care is not necessarily a good predictor of long-term outcomes when they exit the facility.[175] A child's transition process, specifically the post secure care support, is considered to be just as critical to their overall recovery and progress.[176] McLean (2016) notes research suggests the achievement of outcomes in secure care may be related to the quality and continuity of service provision after secure care. Certainly, secure care is unlikely to be effective without a range of options that continue to support children and enable them to continue to gain more control over their behaviour.[177]

The design of a plan to manage the child's transition out of secure care including the provision of ongoing and therapeutic support is essential. In Ireland, prior to the child or young person actually leaving the special care unit, there would be a period of transition whereby the child or young person would visit their new placement and have overnight stays before moving into to that placement on a full-time basis. In Scotland, secure care units include a gradual transition from the structure and supervision of secure care towards a less restrictive setting secure care, with transitional care arrangements for those who no longer require containment, but still require additional support prior to them returning to a less structured environment within the community, and some semi-independent living arrangements with a focus on enhancing independent living skills. A three-year study examining the outcomes of this gradual 'step-down' approach found it was linked to better outcomes. [178]

[175] Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. American Journal of Orthopsychiatry, 71(2), 227.

[176] McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, Australia; Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice.

[177] McLean, S. (2016). Report on secure care models for young people at risk of harm. Report to the SA Child Protection Systems Royal Commission 2016. Australian Centre for Child Protection, University of South Australia.

[178] Kendrick, A., Walker, M., Barclay, A., Hunter, L., Malloch, M., Hill, M., & McIvor, G. (2008). The outcomes of secure care in Scotland. Scottish Journal of Residential Child Care, 7(1), 1-13.

Case study: Sherwood House, NSW

In NSW, following the establishment of its secure care facility – Sherwood House in 2010, a graduated 'stepped down' transition model was subsequently developed utilising a combination of secure and semi-secure options to facilitate ongoing support and continuity with the therapeutic approach. Individual case planning and therapeutic goals is undertaken for each young person entering the program. It is through the revision of these goals that determination of a suitable exit plan and timeline for transitioning is determined.

Sherwood House is not described as a "secure facility" rather, a residential facility with the capacity for containment. This language is deemed important to the flexibility embedded within the facility and its therapeutic approach. The facility has the capacity to restrict children's outside movement when required as part of the therapeutic response, however there are different levels of containment, with children and young people able to go out into the community depending on the level which applies to them at that point in time. Some children go into the community accompanied by a carer; some have unsupervised family visits; others have visits with a carer and with security staff nearby. The level of security changes depending on the identified need, which includes asking the child what they need for support in that instance.

The setting of the facility is also considered important to the program. The facility is on 2.5 hectares of land on the outskirts of Sydney. Sherwood House is described as looking like a standard residential group home, with some subtle changes. The house is secured by a perimeter fence, and the cottages are semi-secure, offering a step down alternative to children as they transition from the unit. All sites offer capacity for containment, via fencing or physical restraint where necessary.

A staged pathway to mainstream schooling has also been established as part of the step-down transition, with Sherwood House children attending Sherwood School on site, then progressing to attending half-day or up to three days a week at a local special school,.

Continuity of Care

Continuity of care for children and young people transitioning out of secure is an issue discussed in the literature. A successful transition process is dependent on ensuring strong consistency with the therapeutic approach at the secure care facility and robust planning for continuity of care and comprehensive services. This is critically important in ensuring that children can be effectively transitioned from secure care services to less intensive OoHC and support services that are able to meet their needs. A lack of continuity following secure care is said to contribute to a child or young person's renewed crisis. Ensuring continuity of cares requires effective integration of services and between all sectors involved in the child and young person's care on exiting secure care and entering the community. Service gaps at any stage of the continuum can potentially compromise the effectiveness of care and sustainability of outcomes achieved in secure care.

In Scotland it is legislated that all young people should have a throughcare and aftercare plan covering a period of at least three months following the day of departure from secure care, to support them in the community as "children in need" under C(S)A 1995". Similarly it identifies that "a placement in secure care must be part of a planned journey through the care system". There is also within the *Children and Young People (Scotland) Act 2014*, which became law in March 2015, the provision that aftercare services for young people leaving care should provide support, defined as 'advice, guidance and assistance', to young people, including those who have been in secure care, up until their 26th birthday.[179] The aim of throughcare and aftercare is to enable and support the young person to make a successful transition to independent adult living. The approach in secure care is therefore always to empower young people to make decisions and take control of their lives and ensure they are in a position to have achieve positive outcomes when they leave. It also involves ensuring that young people are at the heart of the assessment and planning process and fully involved in all aspects of their own throughcare and aftercare.

The report of the Royal Commission into the Protection and Detention of Children in the Northern Territory (2017) noted the need for coordinated throughcare for children and young people leaving facilities where they have been detained. The report recommended an integrated, evidence-based throughcare service be established that provides children and young people with appropriate accommodation, access to all relevant services and a comprehensive wraparound approach facilitated by cross-agency involvement. It also recommended that the service be evaluated at the end of five years with a report to the Commission for Children and Young People, including outcomes.[180] While Western Australia's secure care centre is not a youth justice detention centre, the principle of providing supported transition for children and young people who have been placed in a designated facility and are re-engaging into the community, does have relevance.

Case Study: Integrated Care Framework, NHS

The NHS in England has commenced work to transform the health provision for vulnerable children in the justice system, (this includes those in secure settings which in England include young offender Institutions, Secure Training Centres and Secure Children's Homes). The aim is to improve the support to children with complex difficulties who may be moving between outpatient and inpatient CAMHS settings and other secure settings. An Integrated Care Framework (called Secure Stairs) has been developed as part of this approach. The framework applies to all of the secure settings and seeks to integrate care for children from all of their caregivers and professional helpers. One of the stated objectives of the Framework is to develop a secure outreach provision to support and compliment the work already provided by mental health providers within secure settings to continue such work after discharge. [181]

[179] Moodie, K. (2015). Secure care in Scotland, a scoping study: Developing the measurement of outcomes and sharing good practice.

[180] Commonwealth of Australia (2017). Royal Commission into the Protection and Detention of Children in the Northern Territory. ISBN: 978-1-920838-26-3 (Print). Published November 2017

[181] https://www.rcpsych.ac.uk/pdf/Twitchett%20Caroline%20-%202017-03-16%20slides%20for%20RCPsych%20SIG%20CT.pdf

Addressing the needs of Aboriginal children in secure care

Across Australia there is an over representation of Aboriginal children and young people in OoHC. While they comprise 5.5% of the total population of 0 to 17 year-olds in Australia, they constitute 35.6% of the children and young people in OoHC. The rate of Aboriginal and Torres Strait Islander children placed in out-of-home care rose steadily, from 48.2 per 1,000 children in 2013 to 58.7 per 1,000 children in 2017, while the rate for non-Indigenous children rose slightly, from 5.3 to 5.8.[182]

Legislation and policy in Australian child welfare jurisdictions seeks to address the unique and particular needs of Aboriginal children in care, including their family, community and cultural connections.[183] This includes children and young people having access to information about their own history and heritage, the country to which they belong and the clans to which they are connected. It also includes support and resources to initiate or maintain connection with their community and culture. Legislative and policy provisions aiming to support the cultural needs of Aboriginal children include the Aboriginal Child Placement Principle (ACPP) and Cultural Support Planning. These provisions recognise the importance of connection to family, community, culture and country in child and family welfare policy, legislation and practice. (Family Matters 2018).

Numerous sources suggest it is imperative for Aboriginal children and young people in the child protection system that they are supported to retain connection to culture and family, thereby maintaining and developing their sense of identity.[184] Providing for children's cultural needs in care requires understanding and respect for the worldview of Aboriginal and Torres Strait Islander people, and also the unique differences between different Aboriginal communities and groups including the ways in which they understand and experience connection to culture.[185]

Bamblett et al. (2012) emphasised several factors that need to be considered when supporting a cultural understanding of Aboriginal children and young people in care. These include exploring:

- Who you are (personal identity);
- Who you belong to (family, community);
- Where you belong (country);
- What you do (participation, expression);
- Where you come from (family history, Aboriginal history); and

[182] Australian Institute of Health and Welfare 2018. Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW, p.56.

[183] Libesman, T. (2011). Cultural care for Aboriginal and Torres Strait Islander children in out of home care. Sydney: SNAICC

[184] Libesman, T. Ibid; Hutt, S., & Clarke, A. (2012). Improving Aboriginal and Torres Strait Islander cultural support in out-of-home care. Children Australia, 37(02), 76–79.

[185] Lindstedt, S., Moeller-Saxone, K.,Black, C. , Herrman, H. , Szwarc, J. (2017). Realist Review of Programs, Policies, and Interventions to Enhance the Social, Emotional, and Spiritual Well-Being of Aboriginal and Torres Strait Islander Young People Living in Out-of-Home Care. The International Indigenous Policy Journal, 8(3); Long and Sephton (2011) Rethinking the "Best Interests" of the child: Voices from Aboriginal child and family welfare practitioners. Australian Social Work, 64(1), 96–112.

- What you believe (values, beliefs and practices).[186]

Evidence shows that ensuring cultural connection and cultural safety is vital for Aboriginal children and young people in care, and an understanding of their importance is essential for those working with or caring for them.[187]

The Victorian Commission for Children and Young People's report of their inquiry into services provided to Aboriginal children and young people in out-of-home care (2016) states "Aboriginal children living in out-of-home care have a fundamental right to preserve their Aboriginal identity. Maintaining identity is about remaining connected to family, extended family, local Aboriginal community, wider community and culture".[188] The report defines cultural safety as "an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening."[189] The inquiry found that many non-Aboriginal service systems that interact with and/or case manage Aboriginal children in out-of-home care lack high-level cultural proficiency; and, Aboriginal children in out-of-home care are provided with greater opportunity for meaningful engagement with culture when their placement, case management and guardianship are provided by an Aboriginal Community Controlled Organisation. Among its comprehensive set of recommendations was the need for Aboriginal child in out-of-home care to have access to an Aboriginal mentor who will assist in building their cultural identity and their connection to Country and family, and who will play an active part in supporting their cultural support plan and leaving care.[190]

McDowal et al (2016) found in their survey of Aboriginal children and young people in OoHC that the more young people knew about their background, the greater their interest in, and the stronger the connection they felt with their cultural community. The author suggests that support for continued cultural connection is critical, even though in many situations those caring for children and young people "have limited resources and are provided with little support to facilitate such connections".[191]

With regard to Aboriginal children in secure care it would seem that there are added challenges in meeting their cultural needs and supporting their social, emotional, cultural and spiritual well-being (SESWB) especially when children are a long way from country. Separating young people from their families and

[186] Bamblett, M., Frederico, M., Harrison, J., Jackson, A., & Lewis, P. (2012). "Not one size fits all" Understanding the social and emotional wellbeing of Aboriginal children. Bundoora: La Trobe University.

[187] McDowall, J. J. (2016). Connection to culture by indigenous children and young people in out-of-home care in Australia. Communities, Children and Families Australia, 10(1), 5

[188] Commission for Children and Young People, 'Always was, always will be Koori children': Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria (Melbourne: Commission for Children and Young People, 2016). p.52

[189] Ibid, p.9

[190] Ibid, p.23

[191] McDowall, J. J. (2016). Connection to culture by indigenous children and young people in out-of-home care in Australia. Communities, Children and Families Australia, 10(1),

communities at any time can run the risk of exacerbating feelings of distress and dislocation[192] that can only be heightened at such an extreme period of their lives as when entering secure care.

Staff Capacity

Staff in secure care are tasked with working with some of the most vulnerable children and young people in society. Children and young people in secure care settings spend a substantial portion of their day with their treatment providers. Research highlights that the way children and young people evaluate a secure care service is primarily on the personal qualities of the care workers and the relationships established with them.[193] Other research suggests that factors that may impact or influence treatment outcomes from secure care can include the 'therapeutic alliance' or 'therapeutic relationship' between staff and child along with satisfaction with the treatment provided and the working relationship or rapport between the staff and child.[194]

The literature on the role of staff in secure settings suggests the quality and skillset of staff is central to the success of the therapeutic model and a key component of the effectiveness or otherwise of therapeutic secure care.[195] Staff are also critical to the provision of a consistent approach to children's care, a safe and stable environment with their skills in relationship building deemed of fundamental importance.[196] It is therefore necessary that an organisation is committed to training and supporting staff and that staff are committed to the theory and practice of working therapeutically, culturally appropriately and able to provide a culturally safe environment for Aboriginal children and those from a Culturally and linguistically diverse background. People working around the child and young person in a secure care model need to fundamentally believe in the model and the intervention.[197]

The reality of working in secure care can prove challenging to effective relationship building, especially if there is a very limited time care workers can establish a rapport with children and young people. High levels of staff absence and restrictions on the time staff have to allocate to building good quality relationships can also hinder the impact they might play. Issues raised in the literature around the importance of staff to the effectiveness of therapeutic secure care also included the challenges with staffing. This included a reliance in some centres on agency staff because of the difficulties of retaining

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[192] Libesman, T. (2011). Cultural care for Aboriginal and Torres Strait Islander children in out of home care. Sydney: SNAICC.

193 Kendrick, A., & Smith, M. (2002). Close enough? Professional closeness and safe caring. Scottish Journal of Residential Child Care, 1(1), 46-54.

[194] Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. Clinical psychology review, 26(1), 50-65. Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent–staff relationship in secure residential youth care. Child & Family Social Work, 18(3), 305-317.

[195] McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, Australia.

[196] McKellar, A., & Kendrick, A. (2013). Key working and the quality of relationships in secure accommodation. Scottish Journal of Residential Child Care, 12(1), 46-57.

[197] Verso Consulting Pty Ltd, Evaluation of the Therapeutic Residential Care Pilot Programs, Final Summary and Technical Report, Department of Human Services, Nov 2011

permanent staff in emotionally demanding positions.[198] Other research also highlights that for children and young people in secure care positive relationship development can be very challenging.[199]

Children's Rights in Secure Care

The United Nations Convention on the Rights of the Child (UNCRC, 1989) stipulates that children under the age of *eighteen* are entitled to a special protection because of their status as 'children'. The UNCRC makes particular assumptions about the vulnerabilities of children and asserts that children have the right to protection from harm.[200] However the issue of children's vulnerability and the need to protect children that underpins the secure care concept, is seen by some as working against or in contradiction to ensuring the rights of children. Some regard detaining children without them being accorded due process or rights concerning the adjudication of their actions (or indeed, their non-criminal 'misbehaviour'), and then depriving children of their liberty as in direct contradiction of their rights. In her analysis of Victoria's SWS, Crowe (2016) makes the point that children's right to security within secure care is in competition with their rights to liberty. She suggests 'the best interest of the child' discourse, where the child's best interests are said to be served by containing them to ensure their own safety, actually serves to undermine their right to liberty. Furthermore, any sense of children's agency is limited in that they are subject to what adults or the state determine to be in their best interest and, as such, their rights are "eroded".[201] She states that emphasis on the security and containment of risk means children's rights are presented as a theoretical, subjective and a secondary concern to security.

There are also concerns expressed by children's advocates that despite the 'therapeutic' rather than 'punitive' purpose of secure care, "it is likely that many children would nevertheless view their detention in secure care as a form of 'punishment'." Furthermore, whether such perceptions among children, could facilitate an increased likelihood of their involvement with both the youth justice and adult criminal justice systems.[202] The English Children's Commissioner's publication *Children's Voices* (2017) notes that children regularly referred to themselves as "locked up", or "banged up" and characterised their experiences as a form of punishment, and associated with criminality and law enforcement.[203] A negative impact of this view of secure care was the internalisation of these perspectives where children and young people felt others considered them to be 'criminals' deserving of being detained, which appeared to have a significant

[198] McKellar, A., & Kendrick, A. (2013). Key working and the quality of relationships in secure accommodation. Scottish Journal of Residential Child Care, 12(1), 46-57.; McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. Australian Institute of Family Studies, National Child Protection Clearinghouse. Commonwealth of Australia, Canberra, ACT.

[199] Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent–staff relationship in secure residential youth care. Child & Family Social Work, 18(3), 305-317.

[200] https://www.humanrights.gov.au/convention-rights-child

[201] Crowe, K. (2016). Secure Welfare Services: Risk, Security and Rights of Vulnerable Young People in Victoria, Australia. Youth Justice, 16(3), 263-279, p.266

[202] PeakCare Queensland. Secure Care – Needed or Not? PeakCare Discussion Paper March 2013, p.24

[203] Children's Commissioner for England. (2017) Children's Voices: Review of evidence on the subjective wellbeing of children with mental health needs in England. London, p.22

impact on their sense of self-worth and self-esteem as a sense of despondency about their future.[204] The report notes that across all types of detention, including secure care arrangements, children regarded their situation as a personal failure. The report also notes a level of confusion among children regarding their containment that caused some to struggle "to reconcile the circumstances in which they found themselves, with their own perceptions of themselves as 'good' people who hadn't committed any offence."[205]

In her ethnographic study of girls in a secure care facility in England Ellis (2018) notes the paradoxical situation of secure settings aiming to keep 'vulnerable' girls safe by locking them up, and how their forcible removal worked to reinforce feelings of being punished.[206] She suggests notions of vulnerability and risk are gendered and account for higher rates of girls in secure care who are more likely to be placed for issues relating to sexual practices and thus having their liberty restricted by being identified 'at risk'. Participants' in her study rejected labels of themselves as vulnerable and regarded conceptions of their status as children and in need of protection as failing to accord them any agency or responsibility for their actions. These rigid conceptions also underpin the type and intent of the enrichment activities provided to the girls and, as such, only serve to work against the girl's receptivity to them. She also notes that the expectation from staff that the girls "should 'act like children' left some girls feeling dejected and aware that they did not conform to the type of childhood expected by the unit".[207] She concludes that instead of being 'vulnerable', the girls saw themselves as capable and independent and withstanding adversity and that their rejection of 'vulnerability' highlights a tension in the professional discourses used to justify secure care. She concludes that an implied and simplistic notion of vulnerability with the view of the girls' behaviour as "wrong because they were young", actually places the girls at greater risk of exploitation because important and crucial chances to reframe their actions and future choices were missed.

Along with the rights based discourse, there is also those that advocate the need for ensuring the views of children and young people are accessed and advanced and that this can be critical to advancing their wellbeing and their rights.[208] This research recognises the value of children's perspective as 'consumers' and the importance of recognising them as key players in the decisions that impact on them, especially in OoHC practices.[209] A significant contribution on the voices of children and young people can be found in a series of Report Cards by the CREATE Foundation, the national peak consumer body for children and young people with a care experience. These Report Cards present the views of many children and young people about OoHC, and highlight the critical importance to them of experiencing stability, having people

[204] Ibid.

[205] Ibid, p.10

[206] Ellis, K. (2018). Contested Vulnerability: A Case Study of Girls in secure care. Children and Youth Services Review, 88, 156-163.

[207] Ellis, K. (2018). Contested Vulnerability: A Case Study of Girls in secure care. Children and Youth Services Review, 88, 156-163. p.162

[208] Tisdall, E. K. M., Hinton, R., Gadda, A. M., & Butler, U. M. (2014). Introduction: Children and young people's participation in collective decision-making. In Children and Young People's Participation and Its Transformative Potential (pp. 1-21). Palgrave Macmillan, London; Tisdall, E. K. M. (2015). Children's Rights and Children's Wellbeing: Equivalent Policy Concepts, Journal of Social Policy, 44(4), 807-823.

[209] Bessell, S. (2015). Inclusive and Respectful Relationships as the Basis for Child Inclusive Policies and Practice. International perspectives and empirical findings on child participation: From social exclusion to child-inclusive policies.

who cared about them, receiving consistent support, being able to participate and achieve and having care staff or caseworkers to act in their interests and transitioning out of care successfully.[210]

In England, the Children Commissioner's *State of the Nation: Report 1 Children in Care and Care Leavers Survey* (2015) highlights the views of children and young people in care identified from 2936 surveys that sought to privilege their voices and rights. Among many topics the report card highlights the positive aspects of care children and young people identified which included: Being listened to; having good and supportive relationships with caring adults; making progress personally with your life; having contact with birth family; being ordinary; normal; feeling a member of the family; stability. Aspects that would improve care included: having continuing relationships with carers and professionals and consistency, stability and a sense of belonging. Making sense of the past was very important for many: being able to understand what had happened and getting help with the past.[211] Similarly *Children's Voices* (2017) also notes that despite many children's negative perceptions of their detention, there were a minority who identified a sense of security and safety that they had not experienced in their chaotic lives outside the secure facility.[212]

Evidence of Secure Care's Effectiveness

Secure care has been criticised for a lack of evidence regarding its efficacy. In Australia there is limited research on the impact of secure care on children and young people in a welfare, rather than custodial context. In her 2016 submission to the South Australian Inquiry Professor Sara McLean of the Australian Centre for Child Protection stated that "no research appears to have yet been conducted about the efficacy of this care option".[213] There is also an absence of studies that empirically investigate the effectiveness of various therapeutic models, including Sanctuary. While a lack of evidence of effectiveness is not the same as evidence that the models are ineffective, it does highlight the importance of assessing the impact that these models have.[214]

McLean (2016) suggests that the effectiveness of secure care depends on the suitability of the therapeutic model applied and the quality of therapeutic input, the range of services available to the child within secure care settings given the complexity of their needs, and the type of interactions with clinical staff, as well as the design of purposeful transition planning. Addressing literacy and numeracy difficulties associated with educational engagement as part of the secure care program is also important.[215]

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[210] McDowall, J. J. (2013). Experiencing out-of-home care in Australia: The views of children and young people (CREATE Report Card 2013). Sydney: CREATE Foundation

[211] Children's Commissioner for England. (2015) State of the Nation: Report 1 Children in Care and Care Leavers Survey. London

[212] Children's Commissioner for England. (2017) Children's Voices: Review of evidence on the subjective wellbeing of children with mental health needs in England. London, p.23

[213] McLean, S. (2016). Report on secure care models for young people at risk of harm. Report to the SA Child Protection Systems Royal Commission 2016. Australian Centre for Child Protection, University of South Australia, p.12.

[214] Macdonald, G., & Millen, S. (2012). Therapeutic approaches to social work in residential child care settings: Literature review. Belfast, Northern Ireland: Social Care Institute for Excellence (SCIE).

[215] McLean, S. (2016). Report on secure care models for young people at risk of harm. Report to the SA Child Protection Systems Royal Commission 2016. Australian Centre for Child Protection, University of South Australia.

The NSW Department of Human Services (2012) states that a therapeutic secure care program should achieve the following outcomes:

- the child or young person receives appropriate supports and service to address their behavioural, emotional, educational and mental and physical health needs.
- the child or young person demonstrates skill development and positive behavioural change associated with his or her case plan goals, for example, greater emotional regulation, greater coping strategies to deal with interpersonal conflict and stressful situations and reduced incidences of self-harm.
- the risk to the child or young person arising from their behaviour is reduced to the extent that it can be effectively managed in a community setting.
- the child or young person is able to make a successful transition to a less restrictive community placement setting at the earliest opportunity, such as intensive therapeutic residential care, intensive foster care, supported independent living, relative or kinship care or family restoration.[216]

Determining the effectiveness of secure care is complex. Identifying the components of a well-run secure care facility is a different process from measuring the outcomes of the children and young people involved and determining the effectiveness of their secure care placement. Assessing a centre involves evaluating the methods of assessment, the quality and impact of the immediate provision of safety and psychological and physical containment that staff are able to provide, which are different requirements to measuring outcomes of children and young people.

Many suggest the scale of determining outcomes is too complex. Questions raised include how baselines should be measured; what constitutes a positive (or a negative) outcome; when should these outcomes be measured; should it be on leaving the secure centre or later; and how is it feasible to assert that a particular outcome can be attributed to any particular intervention or placement. Furthermore, is it the effect of secure care on the young person's life while they are being held, or in when the young person moves on through their life that we seek to understand? There have been few longitudinal studies of secure care outcomes and those that have been undertaken overseas have tended to stress that unpicking outcomes from a secure care placement, for examples of three or six months' duration, in the context of a person's childhood, is extremely difficult. In short, there is an evidence gap with regards to both short term outcomes and longitudinal follow-up of children and young people leaving secure care.[217]

To identify change in a child from the time of their admission to their exit at a secure care centre and to determine whether the centre is successful (or not) in improving children's outcomes, requires a mechanism to measure the child's outcomes and use that data to assess impact. The report of the South Australian Royal Commission into Child Protection Systems states that if a secure therapeutic care model

[216] NSW Government Department of Human Services, Out-of-home care service model –Therapeutic Secure Care Programs, May 2012

[217] Moodie, Kristina (2015) Secure Care in Scotland, a Scoping Study: Developing the Measurement of Outcomes and Sharing Good Practice; Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. Children and Youth Services Review, 30(2), 123-140.

is to be established in the State then it is necessary to ensure regular evaluation based on key indicators that measure outcomes for children. Furthermore, the model should be constantly assessed against evidence provided by such evaluations.[218]

There are various types of outcome measurements that can be utilised by secure care centres including:

- Quality of Life Outcomes: outcomes that support an acceptable quality of life (e.g. being safe and living where you want)
- Process Outcomes: the way in which support is delivered (e.g. feeling valued and respected or having a say over how and when support is provided)
- Change Outcomes: outcomes that relate to improvements in physical, mental or emotional functioning (e.g. increased confidence or fewer symptoms of depression).

Measuring the outcomes of children and young people accommodated within a secure care setting involves monitoring all aspects of their life during their stay. In NSW data is collected to track and analyse children's outcomes. This data includes: Case management milestones, Health management goals, Medication management and impacts, Incident profiles, Behavioural scales, Mental health scales, Client wellbeing self-reports, Program participation and community access, Therapeutic goals and progress. While such data may measure important changes whilst a child or young person is in a secure care setting, the issue of how sustainable those outcomes are outside of the secure setting, and what might support or detract from that, remains largely unknown.

In Scotland, the importance of measuring outcomes in secure care was clearly identified by the Government in 2012. The five secure care units were provided with support to develop their own outcomes model by selecting an outcomes tool to develop in a way that would fit the needs of their organisation and could be embedded within their practice.

Case Study: Good Shepherd Centre, Scotland

As one of the five secure care units in Scotland, The Good Shepherd Centre developed a bespoke and sector-leading Outcomes Framework. This framework provides valuable information about the immediate, short-term and long-term needs of the young people and allows the secure care facility to measure young people's outcomes from assessment to exit (monitoring every 10 weeks using data supplied by their own self-assessment; stakeholder questionnaires; care / programmes / health / education teams, etc.). The framework consists of two related, but separate components: a wellbeing evaluation tool and a data recording system. The framework enables the centre to identify and respond to those areas of wellbeing that require intervention for each young person and then monitor the changes that occur throughout their time. The framework also allows the centre to develop resources and new ways of working to help meet young people's needs, and as a result, can be used to evidence improvements in service delivery.

[218] Child Protection Systems Royal Commission, The life they deserve: Child Protection Systems Royal Commission Report, Government of South Australia, 2016.

The framework has been developed within a wider 'whole systems approach' in Scotland - the national *Getting it Right for Every Child* (GIRFEC) framework, which aims to ensure that all parents, carers and professionals work together effectively to give children and young people the best possible start in life and improve their life opportunities.

Good Practice Approaches

Following a review of the relevant literature, the following provides a summary of potentially good practice approaches for secure care facilities.

Therapeutic Approach

Across research, inquiries and recommendations is a recognition of the critical importance of a trauma informed therapeutic approach embedded within secure care services. Designed around a model of care, appropriate frameworks and assessment and intervention tools, this approach works to ensure the entire care facility is capable of addressing the full range of needs and risks presented by children and young people in secure care.

Robust Assessment

It appears that the provision of robust and comprehensive assessment (inclusive of a formalised risk assessment) for children and young people entering secure care is critical to the development of their intervention plan and transition out of secure care plan.

Planned Care and Interventions

The evidence in Scotland shows that once assessed, a child or young person's placement in secure care should be directed by an intensive and tailored care plan that provides for the array of specialist services they require and therapeutic interventions, along with a range of structured activities from a multidisciplinary team. This includes full Educational input and access to National Qualifications and Wider Achievement Awards, working towards a set of goals that contribute to the child or young person's health and wellbeing, hope and aspirations for their life after secure care. This requires the mechanisms that enable children and young people to have an integral role or shared decision making in determining the outcomes of their secure care placement

Comprehensive Transition Planning

A key theme across research in Australia and elsewhere is that integration of secure care services is critical to transitioning and a continuum of care. This link between OoHC services and secure care services is important both at the time of a child's exit from secure care into community and at the point of their entry into secure care, where current supports and interventions have not been effective in meeting a child's needs or addressing their crisis. This integration is viewed as critically important in ensuring that children can be effectively transitioned from secure care services to less intensive out-of-home care and support services that are able to meet their needs.

Skilled Staff

The importance placed on the interactions and 'therapeutic alliance' formed between secure care staff and children and young people highlights the necessity of appropriately skilled and trained staff who can ensure these positive interactions/relationships develop. This includes a range of staff with specialist skills for progressing the child and young person's care, intervention, education and transition plans and goals.

Standards

The examples of Scotland, England and Ireland show the importance of National Care Standards that foster and support a shared understanding, information sharing and a 'whole of system' approach to the care of children and young people at extreme risk.

Duration of Stay

The research overwhelming points to the importance of providing for a duration of stay in secure care that enables the facility to meaningfully and constructively engage children and young people long enough for them to benefit from therapeutic intervention both in the short, medium and potentially longer term.

Tiered Secure Care

The Good Shepherd Centre in Scotland and Sherwood House in NSW show that tiered or step down systems of secure care for children and young people enable them to gradually shift from a high to medium to low level of secure care, and in so doing holds the greatest prospects for a successful and sustained reintegration into the community.

Independent Oversight

An important aspect of assessing the effectiveness and outcomes of secure care and its processes requires independent regulation and regular oversight of secure care centres according to relevant care standards.

Monitoring

Secure care centres with an appropriate outcomes framework, involving suitable and realistic indicators linked to an overarching model of care, enable the routine collection of data from which a range of outcomes can be tracked and measured. The implementation of robust Quality Assurance and Self-Evaluation procedures allows secure care organisations to evidence continuous service improvement.

References

Australian Institute of Health and Welfare 2018. Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW.

Bamblett, M., Frederico, M., Harrison, J., Jackson, A., & Lewis, P. (2012). "Not one size fits all" Understanding the social and emotional wellbeing of Aboriginal children. Bundoora: La Trobe University

Barclay, A. & Hunter, L. (2008). Blurring the boundaries: The relationship between secure accommodation and 'alternatives' in Scotland. In A. Kendrick (Ed.), Residential child care: Prospects and challenges. London: Jessica Kingsley Publishers.

Bessell, S. (2015). Inclusive and Respectful Relationships as the Basis for Child Inclusive Policies and Practice. International perspectives and empirical findings on child participation: From social exclusion to child-inclusive policies.

Bloom, S. L. (2005) The Sanctuary Model of Organizational Change for Children's Residential treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations. 26(1): 65-81.

Bloom, S. L. (2013). The sanctuary model. *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models*, 277-294.

Bromfield, L. M., & Osborn, A. (2007). "Getting the big picture": A synopsis and critique of Australian out-of-home care research (Child Abuse Prevention Issues No. 26). Melbourne: Australian Institute of Family Studies, National Child Protection Clearinghouse.

Child Protection Systems Royal Commission, The life they deserve: Child Protection Systems Royal Commission Report, Government of South Australia, 2016.

Children, Youth and Families Amendment (Security Measures) Bill, 2013, Explanatory Memorandum http://classic.austlii.edu.au/au/legis/vic/bill_em/cyafamb2013547/cyafamb2013547.html

Children's Commissioner for England. (2015) State of the Nation: Report 1. Children in Care and Care Leavers Survey. London

Children's Commissioner for England. (2017) Children's Voices: Review of evidence on the subjective wellbeing of children with mental health needs in England. London

Commission for Children and Young People, 'Always was, always will be Koori children': Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria (Melbourne: Commission for Children and Young People), 2016

Commonwealth of Australia (2017). Royal Commission into the Protection and Detention of Children in the Northern Territory. ISBN: 978-1-920838-26-3 (Print). Published November 2017

Commonwealth of Australia (2017). Royal Commission into Institutional Responses to Child Sexual Abuse. ISBN 978-1-925622-48-5, Published December 2017.

CREATE Foundation. Final Report: Protecting Victoria's Vulnerable Children Inquiry. August 2011

Crowe, K. (2016). Secure Welfare Services: Risk, Security and Rights of Vulnerable Young People in Victoria, Australia. Youth Justice, 16(3), 263-279

Department for Human Services (2007). Children in need of therapeutic treatment: Therapeutic treatment orders. Melbourne: Government of Victoria.

Department for Child Protection and Family Support (2016). Review of the *Children and Community Services Act 2004*: Consultation Paper. Perth, Western Australia.

De Swart, J. J. W., Van den Broek, H., Stams, G. J. J. M., Asscher, J. J., Van der Laan, P. H., Holsbrink-Engels, G. A., & Van der Helm, G. H. P. (2012). The effectiveness of institutional youth care over the past three decades: A meta-analysis. *Children and Youth Services Review*, *34*(9), 1818-1824.

Ellis, K. (2018). Contested Vulnerability: A Case Study of Girls in secure care. Children and Youth Services Review, 88, 156-163.

Explanatory Memorandum, Children and Community Services Amendment, 2010 (Western Australia).

Explanatory Memorandum Children, Youth and Families Amendment (Security Measures) Bill, 2013 (Victoria) http://classic.austlii.edu.au/au/legis/vic/bill_em/cyafamb2013547/cyafamb2013547.html

Fahey, L. (2014). "Who cares": the impact of carer trauma and resilience profiles on capacity to support young people with complex support needs (Doctoral dissertation, University of Western Sydney (Australia).

Family Matters (2018). Family Matters Report 2018, retrieved from http://www.familymatters.org.au/family-matters-report-2018-the-family-matters-report-2018-urges-that-investment-in-prevention-is-critical-to-stopping-our-national-child-removals-crisis/

Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (2000). Preventive intervention for maltreated preschool children: Impact on children's behaviour, neuroendocrine activity, and foster parent functioning. Journal of the American Academy of Child & Adolescent Psychiatry, 39(11), 1356-1364.

Gough, A. (2016), Secure Care in Scotland: Looking Ahead. Key messages and call for action. Secure Care National Project, Centre for Youth and Criminal Justice. October 2016.

Grant, C. (2016) Secure Care Summary Report (Part One): Legislation. Available at: https://www.researchgate.net/publication/308891681_Secure_Care_Summary_Report_Part_One_Legislation

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent–staff relationship in secure residential youth care. Child & Family Social Work, 18(3), 305-317.

Hutt, S., & Clarke, A. (2012). Improving Aboriginal and Torres Strait Islander cultural support in out-of-home care. Children Australia, 37(02), 76–79

Jacob, A., & Fanning, D. (2006). Report on Child Protection Services in Tasmania: October 2006. Department of Health and Human Services.

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. Clinical psychology review, 26(1), 50-65.

Kendrick, A., & Smith, M. (2002). Close enough? Professional closeness and safe caring. Scottish Journal of Residential Child Care, 1(1), 46-54.

Kendrick, A., Walker, M., Barclay, A., Hunter, L., Malloch, M., Hill, M., & McIvor, G. (2008). The outcomes of secure care in Scotland. Scottish Journal of Residential Child Care, 7(1), 1-13.

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. Children and Youth Services Review, 30(2), 123-140.

Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. American Journal of Orthopsychiatry, 71(2), 227.

Libesman, T. (2011). Cultural care for Aboriginal and Torres Strait Islander children in out of home care. Sydney: SNAICC

Lindstedt, S., Moeller-Saxone, K., Black, C., Herrman, H., Szwarc, J. (2017). Realist Review of Programs, Policies, and Interventions to Enhance the Social, Emotional, and Spiritual Well-Being of Aboriginal and Torres Strait Islander Young People Living in Out-of-Home Care. The International Indigenous Policy Journal, 8(3)

Long, M., & Sephton, R. (2011). Rethinking the "Best Interests" of the child: Voices from Aboriginal child and family welfare practitioners. Australian Social Work, 64(1), 96–112

Macdonald, G., & Millen, S. (2012). Therapeutic approaches to social work in residential child care settings: Literature review. Belfast, Northern Ireland: Social Care Institute for Excellence (SCIE).

McDowall, J. J. (2013). Experiencing out-of-home care in Australia: The views of children and young people (CREATE Report Card 2013). Sydney: CREATE Foundation

McDowall, J. J. (2016). Connection to culture by indigenous children and young people in out-of-home care in Australia. Communities, Children and Families Australia, 10(1), 5

McLean, S. (2016). Report on secure care models for young people at risk of harm. Report to the SA Child Protection Systems Royal Commission 2016. Australian Centre for Child Protection, University of South Australia.

McLean, S., & McDougall, S (2014). Fetal alcohol spectrum disorders: Current issues in awareness, prevention and intervention CFCA Paper No. 29 Published by the Australian Institute of Family Studies, December 2014.

McLean, S., Price-Robertson, R., & Robinson, E. (2011). Therapeutic residential care in Australia: Taking stock and looking forward. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, Australia.

McDonald, M., Higgins, D., Valentine, K., & Lamont, A. (2011). Protecting Australia's children research audit (1995–2010) Final report. Australian Institute of Family Studies and Social Policy Research Centre, accessed online http://www. aifs. gov. au/nch/pubs/reports/audit/2011/index. html.

McDowall, J. J. (2013). Experiencing out-of-home care in Australia: The views of children and young people (CREATE Report Card 2013). Sydney: CREATE Foundation

McKellar, A., & Kendrick, A. (2013). Key working and the quality of relationships in secure accommodation. Scottish Journal of Residential Child Care, 12(1), 46-57.

Mercy Family Services (2012) A Series of Papers examining Critical Issues in Child Protection. Brisbane, Queensland.

Mercy Community Services (2016) Secure Care Submission, Brisbane, Queensland.

Milovanovic, S. 'State fails girl living in care and raped', Sydney Morning Herald, 14 December 2009

Moodie, K. (2015) Secure Care in Scotland, a Scoping Study: Developing the Measurement of Outcomes and Sharing Good Practice. [Report]. Available at https://strathprints.strath.ac.uk/61207/

NSW Department of Human Services. (2010). Out-of-home care service model: Therapeutic secure care programs. Sydney: Out-of-Home Care Policy Planning Division: Community Services.

NSW Government Department of Human Services, Out-of-home care service model –Therapeutic Secure Care Programs, May 2012

Ombudsman Victoria, Own motion investigation into the Department of Human Services child protection program (Melbourne: Ombudsman Victoria, 2009).

Ombudsman Victoria, Own motion investigation into child protection – out of home care (Melbourne: Ombudsman Victoria, 2010).

Ombudsman Victoria, Investigation regarding the Department of Human Services child protection program (Loddon Mallee Region) (Melbourne: Ombudsman Victoria, 2011

Ombudsman Victoria, Annual Report 2013 – Part 1 (Melbourne: Ombudsman Victoria, 2014)

Osborn, A., & Delfabbro, P. H. (2006). Research Article 4: An Analysis of the Social Background and Placement History of Children with Multiple and Complex Needs in Australian Out-of-home Care. Communities, Children and Families Australia, 1(1), 33.

Passmore, H. M., Giglia, R., Watkins, R. E., Mutch, R. C., Marriott, R., Pestell, C., ... & Freeman, J. (2016). Study protocol for screening and diagnosis of fetal alcohol spectrum disorders (FASD) among young people sentenced to detention in Western Australia. BMJ open, 6(6), e012184.

PeakCare (2013) Secure Care – Needed or Not? PeakCare Discussion Paper, March 2013. PeakCare, Queensland. Available at: http://c.cld.pw/129/cms/files/SecureCareDiscussionPaperFinal.pdf

Protecting Victoria's Vulnerable Children Inquiry, Cummins, P. D., Scott, D., & Scales, B. (2012). Report of the Protecting Victoria's Vulnerable Children Inquiry. Melbourne: Victorian Government Printer.

Salazar, A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older adolescents in foster care. Social psychiatry and psychiatric epidemiology, 48(4), 545-551.

Sammut, J. (2011). Do not damage and disturb: On child protection failures and the pressure on out-of-home care in Australia. Centre for Independent Studies.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. Infant mental health journal, 22(1-2), 7-66.

Smyth, C., & Eardley, T. (2008). Out-of-Home Care for Children in Australia. Social Policy Research Centre Discussion Paper, (139).

Souverein, F. A., Van der Helm, G. H. P., & Stams, G. J. J. M. (2013). 'Nothing works' in secure residential youth care?. *Children and Youth Services Review*, *35*(12), 1941-1945.

Tarren-Sweeney, M., & Hazell, P. (2006). Mental health of children in foster and kinship care in New South Wales, Australia. Journal of Paediatrics and Child Health, 42(3), 89-97.

Tomazin, F. 'Victoria's most vulnerable youth to get new education program' The Age, 5 October 2014

Tisdall, E. K. M., Hinton, R., Gadda, A. M., & Butler, U. M. (2014). Introduction: Children and young people's participation in collective decision-making. In Children and Young People's Participation and Its Transformative Potential (pp. 1-21). Palgrave Macmillan, London.

Tisdall, E. K. M. (2015). Children's Rights and Children's Wellbeing: Equivalent Policy Concepts?. Journal of Social Policy, 44(4), 807-823.

Verso Consulting Pty Ltd, Evaluation of the Therapeutic Residential Care Pilot Programs, Final Summary and Technical Report, Department of Human Services, Nov 2011

Verso Consulting Pty Ltd., (2011) Evaluation of the Therapeutic Residential Care Pilot Programs, Final Summary and Technical Report, Department of Human Services.

Victoria, Health and Human Services, http://www.cpmanual.vic.gov.au/policies-and-procedures/out-home-care/secure-welfare/secure-welfare-service-placement

Victorian Auditor General (2014) Residential Care Services for Children, http://www.audit.vic.gov.au/publications/20140326-Residential-Care/20140326-Residential-Care.pdf.

Victorian Auditor General (2016) Follow Up of Residential Care Services for Children, Victorian Auditor-General's Office, Melbourne

Walker, M., Barclay, A., Hunter, L., Kendrick, A., Malloch, M., Hill, M. & McIvor, G. (2005). Secure accommodation in Scotland: Its role and relationship with 'alternative' services. Edinburgh: The Stationery Office.

Western Australia, Parliamentary, Legislative Assembly, Tuesday 21 September 2010, Mr A. J. Simpson, p4236c-4238a

Western Australia, Parliamentary, Legislative Assembly, Tuesday 21 September 2010, Mr Whitely, p6962b-6991a

Annexure A: Selection of Inquiries and Statutory Reviews - Child Protection System

Report: Child Protection Systems Royal Commission (South Australia): 'The life they deserve' (2016)	
Relevant Findings	**Relevant Recommendations**
Need for Secure Care in a range of options • There is a need for SC and any such model should have the safeguard of oversight by the Supreme Court. • The SC service should be part of a suite of options available for children in care, with appropriate and well-resourced step-up and step-down services & streamed residential care services. **Therapeutic model must be embedded in Secure Care** • Delivering therapeutic services is a crucial part of the secure therapeutic care model. A model of therapeutic care should be adopted which is sufficiently flexible to be applied across all categories of residential care, and promotes a consistency of approach and standard of care. **Staffing requirements** • SC requires a multidisciplinary team approach and staff who have specialist skills in child development, family dynamics, conflict resolution and responses to challenging behaviour arising from trauma and disability. **Necessity of evaluation and measuring outcomes** • Any secure therapeutic care model which is established should be regularly evaluated against key performance indicators that measure outcomes for children. The model should be constantly assessed against evidence provided by such evaluations.	Recommendation 152: Develop a secure therapeutic care model, supported by legislation, to permit children to be detained in a secure therapeutic care facility but with an order of the Supreme Court required before a child is so detained. The model should include regular evaluation of outcomes for children.
Report: Too hard? Highly vulnerable teens in Tasmania (2017)	
Relevant Findings	**Relevant Recommendations**
Need for a range of service options for vulnerable youth There needs to be a range of appropriate voluntary and involuntary services in place and being delivered in a way that actually meets young people's needs. **Adverse reliance on short term interventions**	Establish a specific program area for Youth at Risk within the Department of Children and Youth Services. Create new care services targeted to highly vulnerable young people both with and without Care and Protection Orders, which include: Intensive family reconnection work, Long-term, therapeutic, mobile case coordination and case work, Innovative medium-term and long-term accommodation options

A lack of capacity and resources drive referral between short-term interventions and underpins the struggle of specialist services – including Child Safety, Youth Justice, CAMHS, Education and SHS – to provide meaningful and lasting intervention. **Need for inter-agency coordination** The provision of care for highly vulnerable teens should be approached as an inter-agency responsibility. There is a need to deepen both the capacity and breadth of specialist adolescent services.	Expand existing specialist adolescent services to include: Trauma-specific mental health services with capacity for assertive outreach, Residential mental health recovery services, Residential drug detoxification and rehabilitation services, Increased capacity and diversity of alternative education options. Include responses specifically targeted to the cumulative risk and needs of highly vulnerable teens in the current redesign and reform of child protection and OOHC services.
Report: Report of the Royal Commission into Institutional Responses to Child Sexual Abuse (2017)	
Relevant Findings	**Relevant Recommendations**
All institutions must be required to uphold the rights of the child. **Need to strengthen and build capacity of carers, staff and caseworkers in therapeutic interventions.**	**Ensuring Chid Safety** **Recommendation 6.8:** All State and territory governments should require all institutions in their jurisdictions that engage in child-related work to meet the Child Safe Standards identified by the Royal Commission should implement the Child Safe Standards identified by the Royal Commission. **The Child Safe Standards are:** 1. Child safety is embedded in institutional leadership, governance and culture 2.Children participate in decisions affecting them and are taken seriously 3.Families and communities are informed and involved 4.Equity is upheld and diverse needs are taken into account 5.People working with children are suitable and supported 6.Processes to respond to complaints of child sexual abuse are child focused 7.Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training 8.Physical and online environments minimise the opportunity for abuse to occur 9.Implementation of the Child Safe Standards is continuously reviewed and improved 10. Policies and procedures document how the institution is child safe. **Responses to children's harmful sexual behaviours** **10.6**: The Australian Government and state and territory governments should ensure that all services funded to provide therapeutic intervention for children with harmful sexual behaviours provide professional training and clinical supervision for their staff.
Need to ensure all those involved in the care of children understand the impact of trauma and abuse on children. **Residential care must be based on an intensive therapeutic model of care.**	**Provision of trauma informed out of home care** **12.11:** State and territory governments and out-of-home care service providers should ensure that training for foster and relative/kinship carers, residential care staff and child protection workers includes an understanding of trauma and abuse, the impact on children and the principles of trauma-informed care to assist them to meet the needs of children in out-of-home care, including children with harmful sexual behaviours.

	12.18: The key focus of residential care for children should be based on an intensive therapeutic model of care framework designed to meet the complex needs of children with histories of abuse and trauma. **12.19:** All residential care staff should be provided with regular training and professional supervision by appropriately qualified clinicians.
Report: Royal Commission into the Protection and Detention of Children in the Northern Territory (2017)	
Relevant Findings	**Relevant Recommendations**
Children and young people are not receiving transition support to maintain their engagement with education after leaving facilities. **A lack of extra-curricular programs can leave children and young people with little to do and in a state of boredom, which contributes to poor behaviour.**	**Education** **16.3**: The Department of Education's Student Support Services: • engage regularly with the schools in youth detention centres to ensure the education needs of children and young people in detention are identified and responded to adequately. **16.4:** The Department of Education and superintendents of facilities base school classes within youth detention centres on ability level and age.
Need to ensure services and staff can provide culturally appropriately support to children. **Delivery of cultural and culturally appropriate activities and programs lack continuity.**	**Cultural considerations** **18.1**: a. implement policies to incorporate Aboriginal cultural competence and safety in the design and delivery of education, programs, activities and services for children and young people in detention b. implement the recommendations of the 2014 review of the youth justice and community corrections recruitment processes targeted at recruiting more Aboriginal staff c. require case management assessments to ascertain a child's personal, family and cultural background, including skin or language group and competence in the English language, and d. establish a working party comprised of representatives of relevant Aboriginal organisations and the department to explore the development, funding and implementation of an enhanced Elders Visiting Program and other culturally appropriate activities and programs.
Need for Individualised case management and a therapeutic and multidisciplinary team approach to children	**Therapeutic case management** **19.1** A case management system be implemented in all youth detention centres: • to manage behaviours in a therapeutic non-punitive, non-adversarial, trauma-informed and culturally competent way to apply to all detainees to include: o ***training case workers in the use of an evidence-based and culturally appropriate individual needs assessment tool***, utilised from admission of a child or young person and on an on-going basis o give case workers access to a manual that is comprehensive, up-to-date and reviewed on a regular basis o ***training and accrediting case workers to deliver therapeutic, trauma-informed and child-centred case management*** to all young people within the detention centres o implementing a ***multi-disciplinary approach to case management*** engaging with relevant stakeholders,

	○ providing each young person with ***individually tailored rehabilitation***, with appropriate programs and services, including drug and alcohol programs ensuring each young person has ongoing access to their case managers, case management programs and activities ○ case management and ***release planning take account of existing therapeutic and rehabilitation interventions*** and maintain their existing relationships with service providers.
Establish independent oversight arrangements	**Oversight** **22.3**: The Official Visitors Program, including recruitment, training and reporting, be a function of the Commission for Children and Young People and the Commission for Children and Young People be required to report regularly to the relevant Minister on the program's activities.
Coordinated and planned transitioning/throughcare **Need for evaluation of transitioning/throughcare services**	**Throughcare** **24.1:** An integrated, evidence-based throughcare service be established for children and young people in detention to deliver: • adequate planning for release including, as appropriate, safe and stable accommodation, access to physical and mental health support, access to substance abuse programs, assistance with education and/or employment • improved exit planning and post-release services to be made available to all children and young people detained more than once or for longer than one week • a ***comprehensive wraparound approach facilitated by cross-agency involvement***, and • planning for detainees to exit from detention as soon as they enter detention. **24.2:** The throughcare service be independently evaluated at the end of five years, with a report to the Commission for Children and Young People, including outcomes and rates of reoffending.
Improve responses to criminal behaviour of children in OOHC **Need for tailored and specific services for children in both care and detention**	**Addressing the needs of children in care and detention** **35.2**:A joint protocol be developed between Territory Families, the out of home care service sector and the police to address the management and response to criminal behaviour in the out of home care environment, with an evaluation of the protocol carried out within two years. **35.5:** Territory Families: • engage specialised caseworkers with training in both child protection and youth detention to work with children who have been, or are, in care and detention, to deliver and coordinate services targeting the needs of the child, to minimise the risk of offending or re-offending and work in co-ordination with any legal service representing the child, and • develop flexible, dynamic services specific to the needs of children and youth in care and detention including: targeted services of high intensity, therapeutic models that focus on meeting the needs and changing the behaviour of the child while simultaneously addressing social and environmental risk factors, and a mentoring and/or visitor program. **35.7:** Develop a ***detailed plan for information-sharing and collaboration between workers in the child protection and youth justice sectors*** of Territory Families, and other relevant agencies.

Annexure B: Selection of Treatment Services in WA for Youth with Extreme Complex Behaviours

Service	Location	Target Group & Capacity	Aims	Therapeutic Approach & Clinical Services
Youth Link **(Tier 4)**	Services in north and south metropolitan areas and Northam	Youths aged 13 to 24 with serious mental illness and those at risk of developing mental illness, those without a fixed address, youth who are treatment-resistant (not attending clinic appointments).	Specialised mental health service for marginalised young people.	Trauma-informed, flexible approach with assertive outreach to support engagement. Services are provided by clinical psychologists, social workers, clinical nurses and ATSI mental health practitioners, with limited psychiatry services also available.
Pathways (Tier 4)	Perth (supporting families from metropolitan Perth as well as rural and remote areas of WA)	Children up to the age of 12 with complex social, behavioural, mental health and developmental issues. Referrals are accepted from Tier 3 services such as CAMHS, Child Development Services, School of Special Educational Needs : Behaviour and Engagement and other specialised services for children.	Provide intensive therapeutic day services and educational support.	Utilises mental health clinicians from nursing, social work, psychiatry, occupational therapy, clinical psychology, speech pathology, as well as teachers, art and play therapists.
Touchstone	Perth metro	Day program for young people aged 12 to 17 who are struggling to cope with relationships, having mood difficulties and impulsive self-harming behaviours.	Works with young people and their families to help them develop ways to better manage their feelings and associated stress.	Program includes individual, group and family therapy sessions as well as schooling. Staff include a consultant child and adolescent psychiatrist and psychoanalyst & therapy team of nurses, psychologists, social workers, occupational, art and creative therapists. Uses the concept of 'mentalising' to help address the difficulties faced by young people individually and within their families.
Multi systemic therapy	The program is composed of two small teams, each with four clinicians	Community-based program for young people aged 12 to 16 years	To help children and families develop skills needed to manage their challenges.	The program is an intensive family intervention that last 3-5 months and treats disruptive behavioural disorders such as conduct disorder and oppositional defiance disorder. The program operates an intensive outreach model with

Service	Location	Target Group & Capacity	Aims	Therapeutic Approach & Clinical Services
(MST) (CAMHS)	and the two teams service two large catchment areas within the south and north Perth metropolitan area.	experiencing serious behavioural problems and are at risk of: • out of home placement – being placed in foster care or the care of the Department for Child Protection and Family Support (external site) • being expelled from (asked to leave) school • entering the juvenile justice system (having criminal law problems). Also works with 10 to 11 year-olds, if their mental health problems are severe. Referrals accepted from School Psychologists, Child &Adolescent Mental Health Services, Child Protection & Family Services, Juvenile Justice, GP's and private health and mental health practitioners.		clinicians visiting the family home 3 x week throughout the intervention.
State specialist mental health units	Princess Margaret Hospital (will be relocated to new Perth Children's Hospital)	Perth Children's Hospital will have 20 dedicated mental health beds for children under 16 years of age.	Provides assessment, treatment and community care planning for young people experiencing complex and severe mental health problems Individual recovery based care designed around Therapeutic Crisis Intervention, Trauma Informed Care and Recovery, Orientated Care 'Recovery and Engagement for Active Lives' (REAL) activity program provides group activities for young people including art, exercise, psycho-education, drug and alcohol education and communication skills.	
	Bentley Adolescent Unit, Bentley. (Soon to be renamed the East Metropolitan	Young people between the ages of 13 and 18. Includes both voluntary patients and involuntary patients who		

Service	Location	Target Group & Capacity	Aims	Therapeutic Approach & Clinical Services
	Youth Unit and will consist of 12 beds)	are admitted are admitted under the Mental Health Act (1996). 12 bed specialist mental health inpatient unit. .	Staff comprised of those with training in psychiatry, nursing, psychology, occupational health and youth work.	
Parkerville Children & Youth Care **Therapeutic Care Programme (TCP)**	Perth metro area	For children 0-17 who have been removed from their biological families and placed into the care of the CEO of the Department of Communities.	To address the needs of children who have experienced a range of traumatic events, including physical, sexual and/or emotional abuse, neglect, exposure to domestic violence, homelessness and poverty.	Provides an intensive and therapeutic programme In-depth assessments are provided for each client and treatment strategies include cognitive behavioural therapy (including relaxation training, cognitive re-processing and exposure therapy), psycho-education, applied behaviour, analysis, motivational interviewing and skills training Provides medium and long term residential care for children, some of whom will return to their biological families and some of whom will transition to a therapeutic foster care placement. The programme uses a multidisciplinary team comprising of Social Workers, Psychologists, Occupational Therapists, a Teacher, and a Paediatrician
Enhanced foster care	Services are delivered by non-government organisations. There is currently movement towards outsourcing all specialised fostering services to the non-government sector.	Placements may be made for children aged 6 to 17 years For children who have experienced abuse, neglect and insecurity and the resultant behaviour means they need individual attention in various areas of their life and cannot live in a home with other children or young people.	A step-down placement for children and young people leaving more restrictive settings (group residential care at the low end or juvenile justice and psychiatric hospitals at the high end) or as a more intensive step-up placement for those whose needs cannot be met in traditional foster care.	A senior support worker, regular consultation and support from a multi-disciplinary team, access to psychological services, educational services and mentors for the child.

Annexure C: Secure Care Comparison Table – Australia

NEW SOUTH WALES			
Relevant Department, legislation & policy	***Criteria, referral & admission process***	***Age of children & length of stay***	***Facility***
NSW Dept., Family & Community Services (FACS). Children in care come under the Children and Young Persons (Care and Protection) Act 1998. Secure care is not legislated in NSW. SC is only provided to children who are case managed by Department of Family and Community Services (not those managed by NGOs). Placement in SC can only be by Supreme Court Order and managed under Supreme Court case management. The duration of the initial order is determined by the Supreme Court. It is usual practice to obtain a seven-day order initially to allow for adequate	For children already living in out-of-home care, who need more intensive and secure support in order to protect them from behaviour that places either themselves or others at risk. Behaviour related to sexual exploitation or substance use also meet the risk criteria. (Note: There are other services in NSW offering secure care that appear to use two-bedroom community houses, with capacity to lock doors where necessary. These are provided in parallel with conventional residential homes, where the capacity to provide secure containment is achieved via physical barriers (locked doors) and physical restraint, rather than high perimeter fencing. This allows services greater flexibility in which clients they can accept. These also do not all appear to provide children with a trauma-informed therapeutic recovery model). Referrals are accepted by department case managers from the Intensive Support Services team. Referrals are initiated as the result of a case conference in which it is decided to apply for a therapeutic secure care order in	Children aged between 12 and 17 years already living in OOHC. The youngest child at Sherwood House was 9 years old. From one week – 24 months (it is uncommon for children to be in the service less than one year)	Sherwood House commenced in 2010 and is the only secure therapeutic residential secure care facility. Provides care almost exclusively to girls since its inception, although it does accept referrals for boys. Sherwood House houses six girls, and has two semi-secure community cottages associated with it, enabling 12 young people to access its service. Since it was established 45 children have been at the secure care facility.

assessment and to make further application to the Court. If satisfied, the Court grants a three-month order. Orders are reviewed every three months by application to the Supreme Court. Further applications to the Court must be made every three months to satisfy the Court that the criteria for SC continue to be relevant.	the Supreme Court. The Director of FACS must approve a therapeutic secure care order application.		
Therapeutic model methodology, principles, care and support arrangements	***Staffing and case management***	***Oversight arrangements, reporting requirements***	***Approach to Transition linkages to other support service***
Sherwood House uses the Attachment Self-Regulation and Competency model. The aim is to manage risk to the extent that a child can be managed in a community setting or other less restrictive placement within the shortest time possible. Identification of individual case planning and therapeutic goals is undertaken for each young person entering the program. It is through the revision of these goals that determination of a suitable exit plan and timeline can be shaped.	Utilises trained mental health and health clinicians to provide oversight and clinical direction to a pool of casual care staff and security guards. Security staff are integrated into training, briefings and de-briefings, and seen as part of the care team and acting as a 24-hour observer. Each child has a psychiatrist and clinical psychologist assigned to them. A dedicated solicitor sits with the case management team three days per week and manages all liaison with the children and young people's independent legal representatives, ensures the court is kept up to date, and that judges and legal representatives are briefed regularly about formulation, progress and trajectory.	Monitoring by the Office of the Public Guardian through reporting and complaints mechanisms, community visitor programs and process evaluation strategies such as child/youth satisfaction surveys. The reporting requirements of the program are matched to regular scheduled Supreme Court review.	There are different levels of care and containment which apply, with children and young people in the facility able to transition to going out into the community depending on the level of security that applies to them. A pathway to mainstream schooling is established as part of the step-down transition, with Sherwood House children attending half-day or up to three days a week at local schools, once they are able to regulate.

	FACS Intensive Case Management team participate in both referral and active case-management of children in SC. Caseworkers will visit once a week.		
VICTORIA			
Relevant Department, legislation & policy	***Criteria, referral & admission process***	***Age of children & length of stay***	***Facility***
VIC Department of Health & Human Services (DHS). Child, Youth and Families Act (2005) Only the Children's court can place a young person subject to an interim accommodation order (IAO) in secure welfare services (SWS). A child taken into emergency care may be placed in a SWS, if there is substantiated and immediate risk of harm to the child, until the matter is bought before the court or a bail justice. Placement of Aboriginal children must include prior consultation with the Aboriginal Child Specialist Advice Support Service.	The following criteria must be demonstrated: (1) placement in a SWS is in the child's best interests (defined by factors relating to the child's stability, development and safety needs), (2) no other available support or placement is adequate to protect the child from significant harm, (3) a SWS place is available and can meet the child's identified needs. There is an initial health screening within 12 hours of admissions for an Aboriginal child and within 24 hours for other children.	Children 10-17 years under a custody or guardianship order or under an interim accommodation order. Up to 21 days (with a 21 day extension in exceptional circumstances). In exceptional circumstances children under the age of 10 years may be admitted to a SWS subject to the approval of the Director, Child Protection in the child's division.	State-wide service delivered in two gender specific 10-bed facilities at Maribyrnong (girls facility) built in 2002 and Ascot Vale (boys facility) built in the 1990s.

Therapeutic model methodology, principles, care and support arrangements	*Staffing and case management*	*Oversight arrangements, reporting requirements*	*Approach to Transition linkages to other support service*
The child can be involved in their planning and goal setting if it is deemed in their interests. Children are informed of their rights relating to detention, review and complaints. The purpose of secure welfare service is to stabilise the crisis, a single incident or an accumulated risk, by addressing immediate safety issues and keeping the child safe while plans are developed or revised to reduce their risk of harm and transition the child to the community as soon as possible.	SWS staff include medical, therapeutic and educational staff and relevant specialist support professionals. A case meeting is held within 48 hours of admission with the family, case worker, carers/staff and care team to review the purpose and goals of the placement, transition plans, and roles and responsibilities. Review meetings are then held every 7 days. Where a care team has not yet been established, this must be identified at the 48 hour planning meeting and established as a priority. Case management is either undertaken by the department's child protection practitioner or may be contracted to non-government organisations (CSO case manager). The child protection worker or CSO case manager has the lead responsibility to coordinate with the care team. This involves providing information about the child, the family circumstances and background at the point of admission to the SWS. The child protection practitioner or CSO case manager	The Commissioner for Children and Young people provides specialist oversight of SWS including monthly staff visits, reviewing incident reports about significant adverse events and administering and overseeing compliance with the Reportable Conduct Scheme. (Note: In March 2016, amendments to the Commission for Children and Young People Act 2012 (Vic) (CCYP Act) came into effect that require the Secretary to the Department of Health and Human Services to disclose to the Commission any information about an adverse event relating to a child in SWS if the information is relevant to the Commission's functions. This has greatly enhanced the CCYP capacity to independently monitor the SWS.	The primary purpose of a transition and exit plan is to facilitate a safe move out of SWS for the child. Every child exiting SWS should have a written plan to support them once they are discharged, which aims to prevent further admissions to SWS. The child protection practitioner or CSO case manager should draft the transition and exit plan in partnership with SWS senior staff and in conjunction with the care team. The plan should incorporate the outcome of any assessments undertaken whilst the child or young person has been placed at the SWS. The child protection practitioner or CSO case manager should ensure that the child has an opportunity to contribute to the formulation of the transition and exit plan. The plan should be shared with the child prior to implementation and their views noted and incorporated into the plan. The child protection practitioner or CSO case manager must ensure that the case planner approves this plan prior to the child or young person exiting the SWS. Each member of the care team is to have a copy of the plan prior to the child's exit from the SWS.

	must keep the care team apprised of the child's progress in the SWS and ensure care team members are informed of arrangements prior to the child or young person returning to a community placement.		Children receive specialised lessons in literacy, numeracy, hospitality, sport and music under the Parkville College program. The education program aims to focus on making the children and young people feel safe and secure within their environment. The program follows a trauma informed practice approach, in which teachers are sensitive to a student's emotional state; they give space, offer choice and allow time for decision-making, with awareness and sensitivity to previous and ongoing trauma.

Annexure D: Secure Care Comparison Table – Scotland

Policy and legislative framework that underpins secure care	Commentary
	The policy focus in Scotland is on wellbeing based, child centred early and effective intervention to children and their families within their own homes, families, and communities to promote wellbeing across the 'wellbeing wheel' (see GIRFEC below) and to further reduce the use of secured care. The Scottish Government established the Secure Care Strategic Board in response to the key messages, findings and recommendations of the *"independent, analytical, strategic and practice focused review"* of secure care, known as the Secure Care National Project, which it had commissioned the Centre for Youth and Criminal Justice (CYCJ) to carry out. In its Programme for Government 2017 to 2018, the Scottish Government committed to: *"develop a strategic approach to responses to children and young people in and on the edges of secure care"* *"develop Secure Care National Standards to improve experiences and outcomes for our most vulnerable young people"* *"establish a transformative model for secure care in Scotland, through a new Secure Care Strategic Board, which will report by end 2018"* The Secure Care Strategic Board established its remit, core purpose, Terms of Reference and the scope of its work streams in late 2017, following the initial Board meeting of 6 October 2017. http://www.gov.scot/Topics/Justice/policies/young-offending/secure-care/StrategicBoard The working Vision Statement agreed by the Board is: **Our vision is of compassionate, nurturing, relational, rights based responses and supports within families, schools and communities; for all children and young people whenever there are concerns about significant harm to self and/or other people.** **We are working together to Get It Right For Every Child, focused on making sure children and young people are offered early, timely, appropriate and high quality supports to help them fulfil their potential.** **Scotland is striving to become a country where all children and young people; whatever the vulnerabilities and risks associated with their distress and actions; are cared for as children and where no child or young person is deprived of their liberty.** **United Nations Convention on the Rights of the Child**

	https://www.unicef.org.uk/what-we-do/un-convention-child-rights/ The work streams of the current Secure Care Strategic Board in Scotland are particularly focussed on Article 39 rights – right to treatment and care following abuse, violence, neglect and trauma etc. and on the interface with Mental Health and CAMHS services
	GIRFEC (Getting It Right for Every Child) is the national approach in Scotland to improving outcomes and supporting the wellbeing of children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them. http://www.gov.scot/Topics/People/Young-People/gettingitright/what-is-girfec/children-and-young-people Includes the Child's Plan http://www.gov.scot/Topics/People/Young-People/gettingitright/childs-plan
	The Children and Young People (Scotland) Act 2014 - significant piece of children's legislation in Scotland became law on 27 March 2014, 18 constituent Parts, introduced significant changes with impact for all stages of a child's life, from birth into adulthood. Important duties on Corporate Parenting responsibilities introduced from intervening and supporting children and families early through to reforms for support to looked after children and care leavers. The Act introduces a duty on Scottish Government Ministers to "keep under consideration whether there are any steps which they could take which would or might secure better or further effect in Scotland of the UNCRC requirements". Public bodies such as Local Authorities and Health Boards/Police Scotland must also now report every three years on what they have done to improve the rights of children and young people. There is a list of which bodies have to do this in the Act. The idea behind GIRFEC is that everyone should work together to ensure that each child has the best start in life. One way the Scottish Government has decided this should be taken forward is to create the role of Named Person. The Named Person will be the person anyone can approach if they have concerns about a child or young person's well-being or if they think they require some help or support. Every child and young person in Scotland up to the age of 18 should have a Named Person. The role is designed to help with all types of problems, not just for times where a child or young person is at risk. This might include where a child or young person needs more short-term support, such as when they are ill, or they have experienced bereavement. The Act provides extra support for looked after young people in care to try and make sure they have the same opportunities as other children and young people. It gives looked after young people the right to stay in the same placement up to 21 where possible, when they feel it's in their best interests to do so. This will be known as continuing care. Local Authorities supporting looked after young people will also have to provide "advice, guidance and assistance" to care leavers up to the age of 26 where this is something that would be helpful to them. http://www.legislation.gov.uk/asp/2014/8/contents/enacted
	Public Bodies (Joint working) (Scotland) Act 2014 The Act requires integration across health and social care for adult services, with local discretion to include integration of children's services. The Act provides for nationally agreed outcomes on health and wellbeing to be set out by Scottish Ministers. The Act establishes integration

	joint boards and integration joint monitoring committees as the partnership arrangements for the governance and oversight of health and social care services. There is a requirement on partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services. Partnerships will be jointly accountable to Ministers, Local Authorities, NHS Board Chairs and the public for delivering the nationally agreed outcomes. This legislation is highly relevant where children's services have been included through integration and thus, has consequences for the joint delivery of services as the health of the child or parents is a common factor when children are on the edge of care. http://www.legislation.gov.uk/asp/2014/9/contents/enacted
	Health and Social Care Standards My Support, My Life These National Health and Social Care Standards set out what anyone should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to, are upheld. The Standards are underpinned by five principles; dignity and respect, compassion, be included, responsive care and support and wellbeing. The standards were developed over the course of three years and are EFQM compliant. The Standards are based on five headline outcomes: • I experience high quality care and support that is right for me. • I am fully involved in all decisions about my care and support. • I have confidence in the people who support and care for me. • I have confidence in the organisation providing my care and support. • I experience a high quality environment if the organisation provides the premises. http://www.gov.scot/Resource/0052/00520693.pdf **The secure care Strategic Board is currently developing National Standards for secure care to sit alongside these**
	The Education (Additional Support for Learning) (Scotland) Act 2004 as amended by the Education (Additional Support for Learning) (Scotland) Act 2009 places duties on local authorities, and other agencies, to provide additional support where needed to enable any child or young person to benefit from education. Young people may have additional support needs and have a right to access help due to a range of learning difficulties and individual circumstances (including being looked after) **Education (Scotland) Act 2016** made amendments to the Education (Additional Support for Learning) (Scotland) Act 2009 http://www.legislation.gov.uk/asp/2016/8/contents/enacted

Looked After Children (Scotland) Regulations 2009

Reflecting the national strategy laid out in Getting it Right, these regulations bring together the care planning services offered to look after children at home with the care provision required when children are separated from their birth parents. They also reflect more detailed and consistent requirements when children are looked after by kinship carers.

http://dera.ioe.ac.uk/1238/1/0099439.pdf

Curriculum for Excellence

The Curriculum for Excellence (CfE) is the national curriculum used from nursery to secondary school. (0 to 18 curriculum) It was implemented in 2010. It comprises a broad general education up to the end of S3 (third year in secondary) followed by a senior phase of learning from S4 to S6. Emphasis is placed on inter-disciplinary learning, skills development and encouraging personal achievement.

CfE is intended to foster four capacities in all young people:

1. successful learners
2. confident individuals
3. responsible citizens
4. effective contributors

https://beta.gov.scot/policies/schools/school-curriculum/

Secure care centres in Scotland are all registered with the regulators as residential school care services and so are scrutinised against the full CfE expectations the same as any other school

National Standards for Youth Justice Provision, Appendix 1 to the National Youth Justice Practice Guidance form a baseline for the Scottish Government National Youth Justice Practice Guidance which is aimed at all professionals who work with young people involved in offending behaviour and offers information, advice and practical assistance in best practice.

http://www.cycj.org.uk/wp-content/uploads/2014/05/Guidance-National_Standards_1-1.pdf

WSA - Whole Systems Approach Underpinned by GIRFEC principles (see above) Since 2011, the Whole Systems Approach (WSA) has been adopted across Scotland to support young people who come to the attention of the Police or are involved with services as a result of offending behaviour. WSA is underpinned by the principles and policy drive of the Scottish Government's Getting it Right for Every Child (GIRFEC) strategic and implementation framework, and has six key elements across three main policy strands: Early and Effective Intervention, which aims to reduce referrals to the Children's Reporter via pre-referral screening; Diversion from Prosecution which aims to keep young people

	away from the criminal justice process, and; Reintegration and Transition, supporting young people who are in secure care and custody, and planning for their reintegration into the community.
	Children's Hearings (Implementation of Secure Accommodation Authorisation) (Scotland) Regulations 2013 aim to ensure that the process around the placement of a child in secure accommodation is fair, transparent and in the best interests of the child. The regulations are intended to strengthen the rights of the child within the secure accommodation decision making process; and to lead to more consistent and standardised decision making practice throughout Scotland. The Scottish Government published related guidance in relation to the regulations (see also Chief Social Work Officer). http://www.gov.scot/Publications/2013/06/9599
	National Standards for the Children's Panel and Practice and Procedure Manual for Children's Panel members set out commitments to children and young people as to panel member practice and ensuring the experience of Children's Hearings has young people at the centre and upholds and promoted their rights and best interests http://www.chscotland.gov.uk/media/20422/national-standards-bw-.pdf http://www.chscotland.gov.uk/media/18967/practice-and-procedure-manual-colour-.pdf
	The Children's Hearings (Scotland Act) 2011 – secure care 'criteria' This provides the legal framework, including specific conditions and what are referred to as the 'secure care criteria' which must be satisfied before a children's hearing issues an order authorising placement in secure care, as defined in section 83(6) of the Act. The conditions which must be met in order for a child to be placed in secure accommodation (the 'secure care criteria') are that: the child has previously absconded and is likely to abscond again; is putting themselves at physical, mental or moral risk; or that the child is likely to self- harm; or the child is likely to cause injury to another person. Once the Hearing issues a Compulsory Supervision Order or Interim Compulsory Supervision Order with secure authorisation, there is a second stage of decision making. The Local Authority Chief Social Work Officer and the Head of the Secure Care Centre which will be responsible for caring for that young person, have certain powers and duties in relation to whether the secure authorisation is implemented. https://www.legislation.gov.uk/asp/2011/1/contents
	The Secure Accommodation (Scotland) Regulations 2013 The regulations set out the definitions and parameters of secure care. The guidance issued alongside these regulations states that: **"Depriving a child of their liberty infringes on one of their most fundamental human rights and impinges on associated rights to freedom of association and family life. For this reason any decision to place a child in secure accommodation can only be justified because it is in their best interests and/or because it will protect the rights of others."** The regulations cover a range of requirements in relation to time

	frames for placements in secure care, duties on local authorities to monitor the welfare and best interests of young people whilst they are in secure care, and the regulation of secure care ('accommodation') itself https://www.legislation.gov.uk/sdsi/2013/9780111020463
Service model - referral & admission process, length of stay	**As noted the legal framework in Scotland complies with the UNCRC in relation to the definition of restriction of liberty as a 'last resort'.** **The National Standards (National Standards for Youth Justice Provision, Appendix 1 to the National Youth Justice Practice Guidance)** States that secure care and detention should be used only when it is the most appropriate disposal, and alternatives have been considered. **The National Standards for Youth Justice Provision in Scotland (Centre for Youth & Criminal Justice, 2013)** recommend reviews for young people in secure care should take place at least monthly and include the young person, their family, secure care staff, the Lead Professional and other relevant professionals. For young people on remand the local authority is expected to arrange a similar meeting to that described for young people sentenced under section 205(2) or section 208 and is usually responsible for taking and disseminating minutes. **Criminal Procedure (Scotland) Act 1995 Young people sentenced under section 44 Criminal Procedure (Scotland) Act 1995:** the local authority may review the young person's case at any time and at minimum of every three months, and this would usual follow local authority procedures for looked after and accommodated children as per **The Looked After Children (Scotland) Regulations 2009 (see Scottish Office, 1997 for further information).** The local authority Chief Social Work Officer, in consultation with the head of unit, must ensure that such reviews are undertaken and obtain advice from a secure placement review panel. This panel must be set up by the local authority responsible for the management of the secure establishment or where the establishment is situated (normally the host local authority). The panel which must consist of at least three persons, none of whom may be the Chief Social Work Officer or the head of unit mentioned above and one of whom must be an independent person who is neither an office holder nor an employee of a local authority or the residential establishment (as per The Secure Accommodation (Scotland) Regulations 2013).As a consequence of any such review and having regard to the best interests of the child and the need to protect members of the public, the local authority may decide to release the young person for a period and on conditions the local authority deems appropriate or unconditionally (as per section 44(6)(b) Criminal Procedure (Scotland) Act 1995). The Child's Plan should be updated following each review. **Young people sentenced under section 205(2) or section 208 Criminal Procedure (Scotland) Act 1995:** within four weeks of entering secure care, the Children and Young Person's (CYP) Placement Manager will schedule a placement review meeting. This meeting will be chaired by staff from the secure unit and attended by the CYP Placement Manager, the young person, their parents/guardians, staff from the secure unit, Lead Professional, and any other relevant professionals. Reports should be provided by the secure unit on the young person's progress and programme proposals, and the Lead Professional on the proposed Throughcare plan. The purpose of this meeting is to determine if this is the most appropriate placement for the young person and the CYP Placement Manager will: • Confirm the placement • Defer the decision until a future date, or • Decide that an alternative secure unit would be more suitable The outcome of this meeting should be reflected in the Child's Plan.

Secure care in Scotland is the most containing and intense form of alternative care available, because young people lose their liberty and have many other freedoms restricted when they are detained in secure care. The law, rules and regulations around secure care are clear that because of this, young people can only be secured in certain situations and for as short a time as necessary to keep them, or others, safe. Secure care is a type of care for a very small number of children and young people, whose difficulties and situations are so extreme that the adults responsible for making decisions about them believe that at a point in time their behaviours and situations pose a very high risk of serious harm to themselves and/or others. Children and young people can be placed in secure care through the Children's Hearings System (the CHS) or the Courts. At present more than 90% of young people who are in secure care in Scotland are there through the CHS, rather than because they have been remanded or sentenced by the Courts. Less than 1% of all children who are looked after in formal care settings are secured each year and the number of children secured by Scottish Local Authorities has been on an overall downward trend for several years (Scottish Government, 2017). Children and young people who are secured are almost always children who have experienced many adverse and difficult experiences which may include physical, emotional and sexual abuse; neglect, bullying, exploitation and loss and bereavement. Many have had difficulties at school and may have additional support needs, for example with speech and language. They are also almost always young people who are already in care or are involved with the CHS (Gough, 2016; Moodie and Gough 2017).

When we interviewed young people who shared their experiences of the day of admission/arrival in secure care, most stated that the route into secure care, that is how they had been informed, involved, prepared and supported; had impacted on how they experienced that admission. Most said they had not been well prepared for the experience of the admission itself. Many for whom this was a first time in secure care, said that no one had really explained to them the extreme restrictions on day to day living arrangements, for example the levels of security, the constant staff supervision and the highly structured routines.

Indeed several young people said that it had not been made clear to them that a decision had been made to secure them. They variously described feeling powerless, angry, confused and shocked and felt they had not been involved at all in the decision making process. A few described having been actively misled by carers and others said that they had not understood that they were going to be taken to a secure care centre. For all of these young people the admission process was particularly stressful and upsetting.

A few young people described themselves as having been *"out of control"* and two said that on reflection, they could see why carers or social workers had not talked with them about secure care for fear that they would run away or harm themselves or others in response. One young person said *"I was off my head"* and would have *"kicked off"* if informed that a secure care placement had been agreed. For the majority, whether they had been well or poorly informed and prepared for the move to secure care, they reported that they had no one they knew well with them during the arrival and admission itself. This meant they had no one they knew well, or who knew them well, with them to support them on arrival in the secure garage, through the process of completing admission questionnaires, having to be searched where this took place, and supporting them towards spending the first night sleeping in a secure bedroom, with no access to a mobile phone, television or radio. Young people said the experience was *"scary," "horrible"* and *"frightening"* and several recalled strong feelings of abandonment and isolation.

Those for whom this was a first admission particularly vividly recalled the sense of anxiety and/or fear about what was going to happen to them in secure care. Young people said that there had not been enough information shared with them or their families at children's hearings, by social workers or by previous carers about secure care, or what to expect and how to ensure their rights. Around a fifth of young people said that they had preconceptions that secure care would be very like a prison setting. Some of those young people who had felt completely unprepared and/or unsupported recalled in detail the journey to the secure centre and the first moments, hours and day in secure. For these young people, the experience appears to have compounded previous difficult care experiences, as most of them were admitted to secure care following a previous care placement breakdown or after particularly difficult crises in their lives. The sense of shock and rejection caused by the sudden separation from everyone and everything familiar was clear.

When we triangulated young people's accounts against the research we undertook with Chief Social Work Officers about secure care, we noted that the majority of placements into secure care were made as 'emergency' admissions, so that the impact of the shock and potential re-trauma from being secured may be exacerbated. **There is no central mechanism for overviewing placement by placement decisions and secure care in Scotland – local authorities purchase individual placements under a framework contract agreement manages by a body Scotland Excel on behalf of the 32 local authorities. The average length of stay is less than four months**	
Therapeutic model - methodology, principles, care and support arrangements	**The Secure Care Strategic Board is beginning to map out definitions in relation to Intensive support; including where this is offered in a containing care environment;** **to provide compassionate, nurturing, relational, rights based care and specialist, personalised support, aimed at:** - **keeping children, young people and others safe** - **preventing and reducing risk of further harm to children and young people and/or others** - **helping young people make sense of past hurts and harm** **Whilst always** - **promoting children and young people's wellbeing and development** - **building hope, resilience and opportunities for their future** **There has been growing momentum in Scotland over the last few years relating to our understanding of the impact of trauma and adverse childhood experiences on development:** **Transforming Psychological Trauma: A Skills and Knowledge Framework for The Scottish Workforce (NHS Education for Scotland 2013) NES** was commissioned to deliver this project as part of the Scottish Government Survivor Scotland Strategic Outcomes and Priorities 2015-2017. The overarching goal is to support the strategic planning and delivery of training for those who have contact with survivors of trauma across all parts of the Scottish Workforce. This sets out helpful information and guidance for everyone working across universal and specialist services. http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf **Codes of Practice for Social Service Workers and Employers of Social Service Workers** – these describe the standards of conduct and practice within which they should work. http://www.sssc.uk.com/about-the-sssc/codes-of-practice/what-are-the-codes-of-practice **The Residential Establishments - Child Care (Scotland) Regulations 1996** Makes provision with respect to residential establishments in which a child who is looked after by a local authority under the Children (Scotland) Act 1995 may be placed. https://www.legislation.gov.uk/uksi/1996/3256/note/made **Guidance on Health Assessments for Looked After Children in Scotland**

This guidance was issued by Scottish Government in 2014, produced to assist those involved in carrying out health assessments of looked after children and young people. It sets out the minimum standardised elements of a health care pathway which Scottish Government would expect Boards to implement in collaboration with local authorities and other organisations. – It is not statutory guidance.

http://www.gov.scot/Resource/0045/00450743.pdf

Healthcare Standards for Children and Young People in Secure Settings, Royal Colleges, 2013

Sets out a pathway and standards for assessment of need and health support and care – across all aspects of physical and mental health and developmental wellbeing - ratified by all four UK Commissioners – operating in England and Wales but not in Scotland

https://rcpch.ac.uk/sites/default/files/2018-03/healthcare_standards_for_children_and_young_people_in_secure_settings_june_2013.pdf

Young people at the thresholds of, and in secure care, are likely to have experienced multiple difficulties (often referred to as adverse childhood experiences, or ACEs) and have additional mental and emotional health and wellbeing needs. Some young people may have unrecognised problems which have been missed, particularly those who have experienced multiple home settings. Young people's day to day functioning and emotional wellbeing has been compromised by past trauma and they require help and support to deal with distress, stress, depression and anxiety. All available information and evidence tells us that secure care should provide positive containment and a therapeutic 'treatment through care' environment and the secure care centres are working towards this in Scotland.

There has been considerable investment across the secure care sector in developing specialist intervention services, where clinicians and qualified health and wellbeing practitioners work together across care, education and support services to ensure that there is a health care pathway, in which the individual needs of each young person are identified, properly assessed and addressed. This happens through treatment and therapeutic interventions, but also through everyone involved with the young person being aware of how to respond to them as an individual in light of their mental and emotional state. In some centres, there are highly effective 'whole system' approaches in place, ensuring that attachment and trauma informed thinking underpins all service development, policy review and practice development, including staff supervision, training and support.

There is evidence from several placing authorities and from the secure care sector that each year, a number of young people at significant risk, often young women, who are involved in life threatening self -harming, are secured, or are sent to hospitals in other UK jurisdictions, as there are not the appropriate alternative services available for them in Scotland. The in reach of CAMHS to young people in secure care is variable and there are tensions and disputes across health board and local authority boundaries in relation to the funding and provision of care. There is no shared understanding or collective vision across health and social care strategies and services in relation to children and young people and trauma. There is little connection between the systems which plan and manage medical secure care (in- patient psychiatric provision) and the secure care sector. There have been longstanding issues in relation to definitions, terminology, language and meaning which are now being explored via the work streams of the Secure Care Strategic Board.

Environment - the facility configuration and layout	There are five secure care centres in Scotland. The centres consist of between one and five locked children's houses; each having five or six individual ensuite bedrooms and each with its own communal living, dining and relaxation spaces. These individual secure children's houses are connected to a school or education base, and recreational spaces, which are in the same building or complex linked by secure corridors. These spaces, for example the classrooms and sports facilities, are also secured. There are very high levels of staff supervision of, and support to, children and young people. Usually there are a maximum of four or five young people in each class or learning group. The secure care centres also employ a range of people including psychologists and therapists, to offer individual and group support and help to young people whilst they are in secure care. The average stay in a secure care centre is around four months but some young people will stay in secure care much longer, for example if they have been sentenced. Although some children in secure care may have committed serious offences, secure care centres are not young offender institutions (YOI). They are registered and inspected by the Care Inspectorate and Education Scotland as residential children's homes and residential school care settings.

Annexure E: KFSCC Assessor Reports – Overview

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
1	Dec 2011 (first assessment report for KFSCC)	• Set up & location of safe room used for incidents is not appropriate • inadequate video recording infrastructure for safe room • Reporting of critical incidents is inconsistent and review processes ad hoc	Integration of SC forms	Met (requires continued monitoring)
			Consider relocation and refurbishment of safe room	Met
			Improve recoding and management of information relating to children especially relating to critical incidents	Not Met / Ongoing (requires monitoring)
			Upgrade visual recording systems for safe room	Met
2	June 2012	• Lack of understanding about therapeutic strategies utilised during placement at SC • Need to better streamline placement referrals from districts • Care plans and exit plans need attention • Critical incident reports only being written by one staff member not all involved	Creation of protocols outlining placement decision hierarchy & facilitate high quality care planning processes and communication between KFSCC & Districts.	Improved but requires ongoing monitoring.

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
		• Provision of professional development and training is ad hoc • notes the low number of children at the centre (1-2) • use of third party for transportation of children to the centre is high risk	Department establishes risk assessment procedures and care standards to manage transport to and from SC by third party. Implement professional development framework and identify and prioritise training gaps. Review critical incident debrief process	Ongoing (requires monitoring) Not Met (no evidence provided to Assessor to suggest this was formally met). Improved but requires ongoing monitoring.
3	May 2013	This report provides detail from interviews with a group of children currently at KFSCC and a group who had recently exited and some of the relevant case workers. Some family/carers were also interviewed.	n/a	
4	Dec 2014	• Procedure for when children first enter the facility on admission is unsafe (through the laundry), and the use of the medical room for their assessment is inappropriate. Processes need to be more flexible to respond to children's different levels of need at admission. • Transportation of children continues to be noted as a concern/risk. • Ongoing document control and management issues.	Audit current security and IT systems, develop security response processes for use in emergencies Review children's admission processes to ensure physical environment is safe and welcoming & reflective of the principles of the Sanctuary model. Update Manual to reflect processes.	Met Met

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
		• The role of the health team and links to the districts and KFSCC staff have improved - with teams observed as working in collaboration. • Notes the increase in children being re-admitted (often within a 4 week period of exiting) and the change in the demographics of children being admitted. • Notes the critical incident process has improved. • Need for strategies for children's transitioning that can capitalise on insights gained about the child while at the KFSCC. • Observes application of the SELF Framework (Sanctuary model) during a critical incident. • Notes the professionalism of staff engagement with children and the introduction of comfort for children such as teddy bears and soft blankets • New process established of senior clinical psych. compiling clinical information at referral and admission appears to be working well. • Significant upgrade to improvements to documentation made available for caseworkers to comply with when making a referral and ensure an appropriate referral.	Confirm transportation framework & risk management plan in place for transporting children from regional areas. Develop overarching flow and document control systems. Explore opportunities to utilise knowledge gained about children to maximise outcomes achieved in SC and enhance and support transitioning/reintegration. Consider development of a transition program. Consider additional strategies to increase collaboration between Increase utilisation of statistics collected to monitor and develop programs	Ongoing (requires monitoring Ongoing Met with opportunities for further improvement and continuous quality being explored. Met Ongoing (activities commenced and will be improved with time)
5	June 2015	• MOU with Police about transport developed but managing transportation risks could be further "matured".	Pursue opportunities to further improve transitioning planning and CQI of transitioning children.	Ongoing - opportunities for improving transitioning are constantly being explored.

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
		• Security and emergency response plans reworked and noted as dramatically improved. • Use of demographic data to improve planning and monitoring requiring ongoing implementation and refinement.	Consider additional strategies for increasing collaboration between health team, district staff and external health providers to support child beyond their stay at KFSCC.	Ongoing - operations of health team continually improving and benefiting from organisational learning.
6	December 2015	• Management identified multidisciplinary team working better together. • Sanctuary model attributed by management with improving communication, supporting staff to be more accountable for their decisions and their rationale. • Improved communication processes although written communications require "extensive review". • Staff survey undertaken regarding communication at KFSCC. • Communication challenges with casual staff and time pressures on all staff. • Concerns about quality assurance and completeness of extension documentation. • Notes the lack of a prescriptive definition under the Act or in Department policy regarding what constitutes an exceptional circumstance to justify an extension to a child's stay - concern this can lead to misuse of districts seeking an extension. • Good reporting of children's education activities and progress.	Case note template to be improved to enhance measurement of outcomes, improve evaluation and increase efficiency. Consider trialling a template. KFSCC consider findings from staff communication survey for solutions to readily improve communication flows. Improve quality assurance processes for documents relating to decisions about SC periods of stay and extensions.	Met Not Met (management did not regard this as suitable) Met

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
7	June 2016	• Notes the centre has developed a "statistical process" to measure a child's behavioural and cognitive patterns whilst in care (involves nine categories of assessment). • Management rejected incorporating changes to communication processes from suggestions from staff survey.		
8	June 2017	• Concerns over reporting of details of children's physical appearance on entry to the centre – inconsistent recording of bruises and wounds etc., • Inconsistencies in terminology used in minutes and actions recorded and status of follow up items • Inadequate adherence to processes for detailing children's personal property log, • Inappropriate processes for referral assessment documentation (completed and signed by same staff member) • Timing of exit meetings is not adhering to guidelines • Goal setting processes with children is inconsistent, ambiguous and not always continuing practices in place before entering SC • Need for improved processes for informing children of their legal rights whilst in SC. • Use of restraints not being adequately or always documented • Gaps in provision of cultural plans from the districts to KFSCC for children	Consider ways to improve record keeping practices for documenting actions and follow up in meeting minutes, consistency of naming conventions in meeting minutes, and documenting use of restraints in meeting minutes. Consider ways to improve documentation of bruises and wounds on child's admission. Clarify timing of exit meetings according to Manual. Identify ways to ensure children sign personal property log & discharge forms.	Met Met Met Met

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
		• Need to improve children's feedback forms about the centre to include complaints/concerns section and to ensure they are explicitly informed it is not anonymous	Consider ways to improve completion of discharge forms.	Met
			Consider oversight arrangements for referral assessment process	Met
			Consult to ensure information provided at discharge meets stakeholder needs & amend accordingly	Met
			Improve development, definition and measurement of secure care goals	Met
			Continue to improve and document processes for informing children of legal rights.	Met
			Review feedback form to provide additional opportunities for children to have their voices heard and to ensure they are aware it is not anonymous & form signed and dated by child.	Not Met (no change to form)
9	March 2018	Notes the centre's management is continuously learning and seeking to improve its operations,	Staff meeting agendas and minutes include ongoing record of progress.	TBC – (at time of publication follow up report was not available)

No.	Date of report	Issues of note	Recommendations and/or required actions	Status of responses to recommendations and/or required actions (as detailed in subsequent follow-up reports)
		especially with regard to reporting, compliance and documentation	Implement regular quality assurance checks of processes for signing personal property logs. Implement regular quality assurance checks to ensure staff complete discharge forms as instructed. Admission checklist be updated to remind staff of obligation to discuss admission information with the child within 48 hours of admission. Regular quality assurance check conducted to ensure staff are providing information to children about their legal rights (corrective actions implemented and noted if staff not adhering). Implement additional measures to ensure staff inform children the feedback form is not anonymous.	

Appendix C. Stakeholders consulted

C.1.1 External consultations

Organisation	Title
Safe Places for Children	[redacted]
Department of Justice – Youth Justice Service	
Parkerville Children and Youth Care (Inc.)	
Commissioner for Children and Young People	
Mental Health Commission	
Drug and Alcohol Youth Service (DAYS)	
Child and Adolescent Mental Health Service – Bentley	
Department of Education	
CREATE Foundation	
Department of Health	
Derbarl Yerrigan Health Service	
Key Assets	
Parkerville Children and Youth Care (Inc.)	
Banksia Hill Detention Centre	

C.1.1 Internal stakeholders

Area	Title
Therapeutic Care Services	[redacted]
Kath French Secure Care Centre	
Other	

[219] Consultation consisted of (i) a focus group at a state-wide District Director Planning Day, and (ii) telephone/email consultation with three District Directors