Government of **Western Australia**
Department of **Justice**
Corrective Services

Response to Review:

Snapshot Series: Recording and Reporting of Self-Harm and Attempted Suicides in Custody

March 2024

Version 2.0

Response Overview

Introduction

The Snapshot Series Review into *Recording and Reporting of Self-Harm and Attempted Suicides in Custody* (the Self-Harm Review) was announced by the Office of the Inspector of Custodial Services (OICS) on 31 October 2023. The Self-Harm Review was a desktop analysis of self-harm and attempted suicide incident data retrieved from the Total Offender Management Solution (TOMS) system.

The draft Self-Harm Review report (draft report) was issued to the Department of Justice (the Department) on 13 November 2023 for review and comment. The draft report highlighted the key findings and made three recommendations.

Following receipt of the draft report, the Department invited OICS to discuss the findings and consider further contextual information as part of the review. This meeting was held on 18 December 2023.

On 22 December 2023, OICS advised the Department to proceed with providing a response to the draft report which included a minor amendment to recommendation two.

The Department has reviewed the draft report and provides below the contextual information and responses to the recommendations.

Review Comments

The Department takes incidents of self-harm and attempted suicide very seriously as they have the potential to lead to a death in custody and welcomes OICS' review into the Department's recording and reporting of these incidents.

The Department is committed to taking all possible actions to prevent or reduce occurrences of self-harm and attempted suicide incidents in custody.

Accurate recording and reporting of these incidents in custody is essential to preventing and reducing such occurrences. It enables the Department to review and analyse the data to identify areas of risk, further develop targeted prevention programs and strategies to minimise these incidents, and to divert critical resources to manage and support at-risk prisoners and detainees. It also enables the Department to fulfil its reporting obligations to national suicide and death in custody reporting agencies.

Definitions can play a key role in accurately classifying incidents for recording and reporting and the Department has given due consideration to OICS' recommendation to align the definition of 'attempted suicide' to that of the Mental Health Commission of Western Australia (MHC).

The MHC definition of attempted suicide is broad as it is intended to guide mental health policy development for government, non-government, communities and private organisations. The definition caters for a multitude of services and client groups which are not specific to the needs of a correctional environment.

The Department's existing definition of attempted suicide is aligned to Gatekeeper Suicide Prevention Training (Gatekeeper), its preferred suicide prevention training program for several years. This training helps staff develop an understanding of the reasons behind suicidal behaviours and the differences between suicidal behaviours and non-suicidal self-injury. The MHC is the custodian of Gatekeeper and trains the facilitators of the training program. Information on Gatekeeper can be found on the MHC website.

Furthermore, the Department's definition is aligned to national reporting guidelines which allows Western Australia's self-harm data to be compared with other jurisdictions in national reports such as the Productivity Commission's Report on Government Services.

The Department has made several changes to policies and procedures in relation to self-harm and attempted suicides over the years, including changes to the incident reporting module in the TOMS system, making it simpler for staff to categorise and accurately record and report on such incidents.

In youth custodial settings, changes have been made to the At-Risk Management System (ARMS) and the Support and Monitoring System (SAMS) which further support staff in the identification and management of young people who are at risk. This allows more accurate reporting through the transparent recording of the identification, referral, interim management plan and case management of the young person. More importantly, it enables appropriate supports and services to be facilitated for the at-risk individual.

A tiered governance process has been implemented whereby a number of people at the local level review the self-harm and attempted suicide incidents for accuracy purposes before the occurrence type is finalised. In addition, the Department's Data Integrity Working Group reviews incidents as part of regular quality assurance checks of the incident data to ensure the recording and reporting is accurate.

Incidents of self-harm and attempted suicide unable to be clearly categorised due to their subjective nature and/or lack of recorded information are referred back to the custodial facility for clarification. At times, they are also referred to the Prisoner Risk Assessment Group (PRAG) for adults and the At-Risk Assessment Group (ARAG) for young people for further assessment of the level of risk and necessary monitoring and supports that may be required to manage risks.

The PRAG and the ARAG comprise multidisciplinary teams, including clinical staff. The core role of clinical staff is to provide clinical interventions and assessments which support the delivery of at-risk management in prisons.

A clinical review process for all self-harm and attempted suicide incidents as recommended by OICS would redirect the clinical resources available to deliver essential clinical services to prisoners and detainees across the custodial estate. It would not only blur the lines between operational and therapeutic roles, but also add a significant burden on clinical staff who already have competing priorities and high workloads.

To differentiate between a self-harm threat and a suicide threat, the Department has recently introduced a new *suicide – threat* occurrence type within TOMS. This is to accurately capture incidents involving threats of suicide that may require clinical intervention and threats of self-harm that do not escalate into actual acts of self-harm and/or attempted suicide.

The correct application of the new occurrence type is a priority for the Department, including ongoing education and training for staff on incident recording and reporting, along with refining its incident review and monitoring governance processes.

It is also the view that a desktop review when considering the complex nature of suicide attempts, suicidal ideation and self-harm is not an appropriate form of review mechanism and does not allow for the consideration of the inherent complexity needed to provide recommendations regarding self-harm or suicide attempts within a custodial setting, even within a data analysis perspective. A desktop review would usually be utilised as a research methodology for statistical clarification and oversight and not a recommended standard methodology for policy development when considering the complex nature of mental health issues and suicidal ideation that may occur in some cohorts of young people within youth detention. This desktop review has also referred to assumptive statements regarding

unrecorded incidents, YCO behaviours and digital literacy that have likely influenced OICS recommendations that the Department has not supported.

The Department however remains committed to working with relevant stakeholders to improve its systems and processes for accurate recording and reporting of self-harm and attempted suicide incidents and giving at-risk prisoners the best level of mental health care and treatment possible to ensure their continued safety and wellbeing.

Response to Recommendations

1 Review the definition of 'attempted suicide' in COPP 13.1 Incident Notifications, Reporting and Communications and in the At-Risk Management System (ARMS) Manual and align with the Mental Health Commission of Western Australia.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

The MHC's attempted suicide definition is broad and guides mental health policy development for government, non-government, communities and private organisations. The definition caters for a multitude of services and client groups which are not specific to the needs of a correctional environment.

The Department's existing definition of attempted suicide is aligned to its preferred suicide prevention training program called Gatekeeper Suicide Prevention Training. It guides staff in developing an understanding of the reasons behind suicidal behaviours and the differences between suicidal behaviours and non-suicidal self-injury. The MHC is the custodian of Gatekeeper and provides the training to the Department. The recommendation was reviewed against the current training provided by MHC and COPP 13.1 and the ARMS Manual and the current policy is supported to remain in place.

Changing the definition of attempted suicide would also cause confusion for custodial staff as it would be inconsistent with the training material and departmental messaging in at-risk management. The current governance processes in place enable any anomalies to be rectified and ensure oversight of recording of these types of incidents is maintained.

2 **Introduce a clinical review process of all self-harm and attempted suicide incidents to ensure the classification applied is accurate, enabling the Department to have accurate and informative oversight.** *(Amended post receipt of draft report)*

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

The practicality of a clinical review process is not feasible due to the shortage of clinical resources in the community and the challenges faced by the Department in recruiting clinical staff to adequately provide essential clinical services to prisoners and detainees across the custodial estate.

The core function of clinical staff is to provide clinical interventions and assessments which support the delivery of at-risk management in prisons. If a clinical review process is

introduced, this would divert the already limited clinical resources from this core role and reduce the available support for at-risk individuals in custody.

3 Introduce a 'suicidal behaviour' occurrence type for incident reports to accurately report incidents of prisoners or detainees thinking, planning or threatening suicide.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

The Department has recently implemented a new *suicide – threat* occurrence type in the TOMS system. This new occurrence type would work in the same way as the proposed suicidal behaviour occurrence type and is expected to improve the accuracy of self-harm and attempted suicide incident recording and reporting.

The new occurrence type differentiates self-harm threats from suicide threats, noting that not all self-harm incidents have suicidal intentions. It also aligns with the Department's ARMS manual and increases reporting and awareness of a prisoner or detainee verbalising suicidal intentions but not actually self-harming.

The actions undertaken by staff in accordance with policy and procedures for threats or acts of self-harm are consistent across the two categories and include the referral to ARMS, increased monitoring, review and facilitation of contact with services and supports.