Detention Services Manual
Chapter 6 - Detention health
Identification & support of survivors of torture & trauma

ABOUT THIS INSTRUCTION

This instruction comprises:

- Introduction
- The policy context
- Overview of torture & trauma
- Principles
- Roles & responsibilities
- Torture and trauma response process
- Dealing with complex issues.

Related instructions

- DSM - Chapter 1 - Legislative & principles overview - Service delivery values
- DSM - Chapter 6 - Detention health - Psychological support program (PSP)
- DSM - Chapter 6 - Detention health - Mental health screening
- DSM - Chapter 6 - Detention health - Mental health policies- Application to minors in immigration detention

Latest changes

Legislative

Nil.

Policy

This instruction, which is part of the centralised departmental instructions system (CDIS), was reissued on 24 March 2012 to update the owner details and to include a definition section - see section 1 Definitions.

Owner

Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office.

Contents summary

INTRODUCTION

This part comprises:

- section 1 Definitions
- section 2 Purpose
- section 3 Scope
- section 4 Background
- section 5 Intended audience.

1 DEFINITIONS

Community detention external service providers: the providers contracted by the department to deliver primary community and welfare support to persons in community detention.

Department: the Department of Immigration and Citizenship.

Detention services provider (DSP): Organisation contracted by the department to manage all operational and general welfare aspects of immigration detention facilities.

Health discharge assessment (HDA): A summary that informs any future health care providers of the clinical history of a person whilst in detention, any treatment received, and ongoing treatment requirements, and any health critical incidents which may have occurred.

Health induction assessment (HIA): An assessment of a person in detention to determine the person's health status, undertaken shortly after being accommodated in a place of detention.

Health services manager (HSM): Health services organisation contracted by the department to facilitate access to health care for persons in immigration detention. The current HSM is International Health and Medical Services (IHMS).

2 PURPOSE

The purpose of this instruction is to describe arrangements to ensure that persons in immigration detention who have experienced torture and trauma are:

- identified as early as possible based on clinical presentation, available background and country information
- connected as soon as possible with appropriate services to assist them with any aspect of their experience of torture and trauma, in such a way that they can avail themselves of these services as freely as possible
- encouraged and supported, wherever possible following consideration of health, character and security risks, to reside legally in the community while their immigration status is being resolved or, where this is not possible, in the least restrictive form of detention to minimise the potential for immigration detention to exacerbate any vulnerabilities associated with their previous experience of torture and trauma. Continued accommodation of survivors of torture and trauma in an immigration detention centre is only to occur as a measure of absolute last resort where risk to the Australian community is considered unacceptable
- actively managed to an immigration outcome as quickly as possible.

This instruction does not attempt to provide a complete guide to the complex set of issues surrounding torture and trauma. The information provided here should be seen as articulating principles and high level processes that must be supplemented by operational procedures and training for the full range of staff working in the immigration detention environment.

3 SCOPE

This instruction applies to all persons in immigration detention, irrespective of the detention placement.

It provides:

- contextualising information about torture and trauma

- principles guiding a best practice response to survivors of torture and trauma
- processes to identify persons entering the detention network who may be survivors of torture and trauma
- processes to manage cases involving torture and trauma through to release from detention.

The instruction does not provide:

- detailed arrangements for processing and support of survivors of torture and trauma who are not taken into, or released from, detention through the grant of a visa. Instead, it provides an indication of which areas and programs are responsible for such support
- detailed guidance on the management of any removal, which may be required for survivors of torture and trauma who have exhausted all options to remain in Australia. Instead, it provides some guiding principles to inform the management of these cases.

4 BACKGROUND

The potential for the experience of immigration detention to compound psychological damage caused by previous torture and trauma demands a carefully considered response by health services and other staff working in the immigration detention environment.

In response to a recommendation by the Immigration Detention Advisory Group (IDAG) in 2007, the Department of Immigration and Citizenship (the department) worked with the Detention Health Advisory Group (DeHAG), and particularly its Mental Health Sub-Group (MHSG), to develop a best-practice approach to the identification and support of survivors of torture and trauma in immigration detention. This instruction reflects the results of this collaboration.

This instruction is informed by government policy that identifies immigration detention as a last resort, and incorporates a presumption that persons will remain in the community unless there are substantial grounds to justify their detention following consideration of health, identity and security risks.

5 INTENDED AUDIENCE

The intended audience for this instruction is all persons who interact with, or advocate for, persons in immigration detention, including:

- the department, including staff working:
  - at places of immigration detention and in policy roles
  - in case management, enforcement and policy roles and
  - state and territory office staff who interact with persons in detention
- the DSP
- the HSM and
- the Community detention external service providers.

THE POLICY CONTEXT

This part comprises:

- section 6 Pathways into detention for survivors of torture & trauma
- section 7 Differing levels of risk & response
- section 8 Options for placement & status resolution
- section 9 A risk management approach.

6 PATHWAYS INTO DETENTION FOR SURVIVORS OF TORTURE & TRAUMA

Survivors of torture and trauma may enter immigration detention via two main pathways. In recent years, common pathway has been by entering the migration zone as an unlawful non-citizen at an ***excised offshore place***. For convenience, this is referred to as the Offshore pathway.

A further group arrive onshore into Australia (not an excised offshore place) and are either an unlawful non-citizen at the time of entry or the holder of a visa which subsequently ceases or is cancelled. This is referred to as the Onshore pathway.

Offshore pathway

Offshore entry persons are generally irregular maritime arrivals, and are taken to Christmas Island for initial processing and consideration through an administrative process of any claims to remain in Australia. The nature of this caseload is such that torture and trauma must be considered likely. Arrangements on Christmas Island differ in some important respects, and differences will be discussed where appropriate.

Onshore pathway

Persons who are taken into immigration detention onshore in Australia generally fall into the following two categories:

- persons who enter the migration zone, other than at an excised offshore place, and are an unlawful non-citizen on entry into the migration zone. These persons are generally:
  - illegal foreign fishers (IFFs) - see PAM3: Act - Act-based visas - Enforcement visas (IFFs are considered very low risk for torture and trauma)
  - unauthorised air or sea arrivals
- persons who arrive lawfully but subsequently become unlawful non-citizens.

Illegal foreign fishers are detained and generally removed quickly and torture and trauma is not considered likely. Some unauthorised air or sea arrivals are removed quickly, while others may seek to remain in Australia and may remain in detention while their claims are assessed. Torture and trauma is more likely among unauthorised air or sea arrivals.

Persons who arrive lawfully and live in the community prior to being detained come from situations known to be high risk for torture and trauma.

7 DIFFERING LEVELS OF RISK & RESPONSE

The prevalence of torture and trauma will be higher in some groups and almost non-existent in others. In line with the principles articulated in the Detention Health Framework, the detention health system will be geared towards closer examination where risks are known to be higher. Specialised screening and assessment will therefore be provided automatically for some groups, for example unauthorised arrivals from geo-political situations known to be high risk for torture and trauma. At the same time, everyone entering immigration detention, including through pathways considered to present a lower risk for torture and trauma, will undergo universal health screening designed to detect signs of psychological distress. This screening will make it possible to identify mental health issues and other presentations compatible with a history of torture and trauma, and referrals will be made for specialist assessment where indicated.

8 OPTIONS FOR PLACEMENT & STATUS RESOLUTION

The inevitable entry of survivors of torture and trauma into immigration detention means that processes are required within the detention system to identify survivors of torture and trauma, to review the reasonableness of their ongoing detention, and to respond appropriately, either by seeking their release from detention or arranging the supportive placement possible within the detention network.

Use of community detention

Since 2005, community detention (*residence determination*) has been the most frequently used option for reducing the health risks associated with the detention of survivors of torture and trauma.

Torture and trauma is a flag for referring a person to the Minister for consideration of placement in community detention - see:

- DSM Chapter 2 - Client placement and
- PAM3: Act - Compliance and Case Resolution - Case resolution - Case management - Minister's residence determination power.

9 A RISK MANAGEMENT APPROACH

This policy adopts an approach that seeks to manage the risks associated with persons who have had traumatic experiences that predispose them to health risks in the detention environment. In this context, the threshold for preventative action is the risk of harm, not actual damage.

Any process which confers a benefit is open to the risk of abuse. However, the risk of failing to identify and provide appropriate support to a survivor of torture and trauma far outweighs this risk. Moreover, the key immigration detention values effectively eliminate the relative benefits conferred on survivors of torture and trauma in relation to others in detention. In this context, detailed assessments for the purpose of determining genuineness are only warranted where a person poses a risk to the Australian community that needs to be carefully weighed against health risks associated with remaining in immigration detention.

OVERVIEW OF TORTURE & TRAUMA

This part comprises:

- section 10 Identification of survivors
- section 11 Definition of a survivor of torture & trauma for the purpose of health referral & therapeutic support
- section 12 Engaging assistance from specialist torture & trauma services
- section 13 Children & adolescents
- section 14 Staff training.

10 IDENTIFICATION OF SURVIVORS

Identifying persons who have experienced torture and trauma is complex as not all have obvious physical or psychological signs. Persons with post traumatic conditions may not necessarily wish or feel safe to mention the fact that they have had a traumatic experience when they first see a doctor or another health professional. Shame, guilt and socio-cultural implications of their mistreatment may become barriers in the process of disclosing torture and trauma experiences. Thus, torture and trauma survivors may present with any of a range of problems, including anger, relationship problems, poor sleep or physical health complaints such as fatigue, headaches or gastrointestinal problems. The distress and stigma associated with mental health problems may also prevent some persons from talking about their experiences.

Torture and trauma experts caution against an overemphasis on Post Traumatic Stress Disorder (PTSD) and other formally diagnosable disorders as evidence of torture and trauma, arguing instead that it may be preferable to speak of "post traumatic mental distress" and "post traumatic conditions". Typically, PTSD is not the most common post traumatic reaction in traumatised populations. Often depression, generalised anxiety disorder, and no disorder are more common than PTSD. A variety of other disturbances related to mood and behavioural regulation, and interpersonal functioning, may be clinically significant but are not formally diagnosable.

11 DEFINITION OF A SURVIVOR OF TORTURE & TRAUMA FOR THE PURPOSE OF HEALTH REFERRAL & THERAPEUTIC SUPPORT

This policy is concerned only with defining a survivor of torture and trauma for the purpose of responding to special needs, including health referrals and optimal accommodation, to avoid compounding any pre-existing vulnerabilities associated with previous torture and trauma. In this context, the threshold is deliberately set low.

In defining *torture* in this context, the department takes an inclusive approach that incorporates any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person. *Trauma* refers to negative physiological, psychological or social responses to such events. The definition also incorporates persons who are traumatised through their relationship to a survivor of torture (for example, a close family member) and persons who have been traumatised through any war-like or refugee-like situation (for example, women who have lived with a constant fear of rape, or who have survived rape, while in refugee camps).

To be defined as a survivor of torture and trauma for the purpose of health referral and therapeutic support, it is sufficient that a person discloses such experiences or, in the absence of disclosure, that the health service provider or a specialist torture and trauma service holds a high index of suspicion that the person has had such experiences.

12 ENGAGING ASSISTANCE FROM SPECIALIST TORTURE & TRAUMA SERVICES

In the immigration detention environment, the HSM plays an important role in identifying persons who may be survivors of torture and trauma. In addition, this policy recognises the need to offer specialist assessment, and if necessary treatment, by an independent torture and trauma service. The FASSTT is the peak body for torture and trauma services in Australia. Specialist torture and trauma assessments and treatment recommendations under this policy will be provided by a FASSTT service, unless there are exceptional circumstances, in which case this should be formally acknowledged by senior management as described in section 30 Escalation of complex issues.

Torture and trauma services affiliated with FASSTT can provide:

- an account of any indications of torture and trauma
- results of screening procedures for formal disorders
- advice on the most appropriate options for care and support.

13 CHILDREN & ADOLESCENTS

Australia has international obligations under Article 39 of the Convention for the Rights of the Child to "take appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of…torture or any other form of cruel, inhuman or degrading treatment or punishment…".

Children and adolescents may experience or witness torture and trauma, and their responses to their experiences will vary by age and level of support. Children are often unable to verbalise their experiences of trauma. In such cases, the health service provider should take steps to obtain assistance from specialist services with expertise in working with traumatised children and adolescents. This is particularly critical with unaccompanied minors.

Also refer to: DSM - Chapter 6 - Detention health - Mental health policies - Application to minors in immigration detention.

14 STAFF TRAINING

Staff who work with persons in detention, including DSP, departmental detention officers and case managers and the HSM, must have some level of training in identifying and/or responding to survivors of torture and trauma. Torture and trauma awareness training will also be incorporated into training for other staff working in areas with a role in managing the pathways into and out of immigration detention, staff working at Australian air and seaports and compliance officers working in the field.

The nature of this training will vary considerably by role, with health staff requiring the most in-depth training. Training and guidelines for HSM conducting HIA should focus on recognising possible signs and symptoms of torture and trauma, understanding the implications of cultural diversity for the identification of idioms of distress, and avenues for seeking assistance when faced with challenging presentations. HSM must also be competent to provide practical risk management advice to the department and the DSP in relation to survivors of torture and trauma.

Non-health staff working directly with persons in immigration detention are not expected to be able to identify signs and symptoms of torture and trauma, though they are encouraged to have an awareness of these. They must, however, be aware of how torture and trauma can affect survivors and be able to interact with persons identified as such in a way that seeks to avoid re-traumatisation. They must also be able to pick up general signs of psychological distress which should trigger a health referral.

As a minimum, training for all staff should include the following issues:

- the socio-political background to torture and trauma
- recognising signs and symptoms of torture and trauma (from basic to advanced, depending on role)
- cultural issues as they relate to the expression of trauma
- routes and processes for referral to health services for persons for whom torture and trauma risk indicators are identified.

Training should be nationally consistent and delivered in an ongoing format.

PRINCIPLES

15 PRINCIPLES UNDERPINNING THE IDENTIFICATION & SUPPORT

The following principles underpin the identification and support of survivors of torture and trauma in immigration detention:

15.1 Early identification and response is critical

There is strong evidence of the effectiveness of early intervention for persons with histories of torture and trauma who have developed symptoms. Excluding the assessment of self-harm risk conducted by the DSP immediately upon entry to immigration detention, the first major opportunity for identification of survivors is the HIA. This assessment needs to ask direct but sensitive questions about histories of trauma, detention, exposure to violence and loss, and to be alert to physical signs and symptoms suggesting a history of torture and trauma. All subsequent mental health screening and assessments must also be alert to such signs and symptoms.

In cases where self disclosure or third party information raises concerns at a later point in a person's period of detention, this must trigger trauma assessment as soon as possible.

15.2 Useful therapeutic work does not depend on full disclosure

Depending on the circumstances it may take as long as a year or more before some persons are willing to talk about their trauma. Even following disclosure to a clinician, readiness to receive treatment is highly variable and does not necessarily correlate with evidence of symptoms. Some persons are ready and have acute symptoms requiring immediate attention. Others, even those who may be highly symptomatic, may not be ready and need to be given the option of accessing treatment at a time of their choice.

Unwillingness to disclose or accept treatment initially does not mean that useful therapeutic work cannot be done from the outset. Interventions that seek to reduce risk factors and strengthen protective factors can be pursued regardless of a person's willingness to seek treatment. The process outlined in this instruction must respond in a supportive and appropriate way to persons who are not yet ready to disclose or accept treatment.

15.3 Balance the need for timely communication with respect for privacy & confidentiality

The importance of timely communication between the various parties who have a role in identifying and providing support to survivors of torture and trauma in immigration detention cannot be overstated. Tempering this is the need to respect privacy and confidentiality when communicating private health information. While this balance can be difficult to achieve, parties must work together in the best interests of the individual.

See also section 28 Balancing the need for timely communication with privacy & confidentiality requirements.

15.4 Expedited placement into the community

Advice from trauma experts indicates that a survivor's torture and trauma memories can be triggered as a direct result of confinement in an environment that has a strong resemblance to contexts in which they have been tortured, and that placement in an environment perceived as "safe" by the survivor is a prerequisite to an effective treatment response. This policy stops short of stating that no survivor of torture and trauma will ever be accommodated in an IDC following consideration of health, character and security risks because there have been, and may again be, cases where a survivor presents genuine security concerns and may even have been a perpetrator of torture. However this situation is rare and the intention for the vast majority of survivors is rapid placement in the community.

15.5 Screening is necessary but not conclusive

Notwithstanding the best torture and trauma screening and assessment, some level of over and under identification must be expected. This policy recognises that it is preferable to set a relatively low threshold to trigger referral for specialist clinical assessment. This is consistent with a harm prevention approach, and avoids the more serious risks associated with failing to identify persons with torture and trauma histories.

15.6 Flexible application of this policy is critical

The approach to torture and trauma assessments and response needs to be flexible. The highly variable experiences of survivors of torture and trauma and the very different detention environments onshore and on Christmas Island require a high degree of flexibility when approaching torture and trauma assessments and response. Examples include whether to use particular screening instruments where these may compound distress; whether to work with persons individually or in groups; and whether to pursue less restrictive placements if this would result in separation from a supportive group.

See also section 29 The need for flexible application of this policy.

15.7 Case conferencing approach

A multidisciplinary "case-conferencing" approach involving clinicians, the department and community-based service providers will be used, with regard to the individual's consent and appropriate limitations on the disclosure of confidential health information. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary, and include one or more internal and external providers and, if possible and appropriate, the individual and close supports. This reflects the reality that an effective response may need to address a wide range of needs including medical, legal, social and psychological assistance.

15.8 Well-trained and supported staff

The approach set out in this policy is critically dependent on high quality training that equips staff to be aware of and respond appropriately to issues that are not well understood in the Australian community. Various levels of training will be provided to DSP, departmental and HSM staff working with persons in immigration detention, and to other staff working in areas with a role in managing the pathways into and out of immigration detention.

See also section 14 Staff training.

ROLES & RESPONSIBILITIES

This part, which is to be read in conjunction with Torture and trauma response process, comprises:

- section 16 Generic responsibilities
- section 17 The critical role of the departmental case manager
- section 18 Specific roles & responsibilities.

16 GENERIC RESPONSIBILITIES

All parties are expected to:

- share information relevant to the identification or support of survivors of torture and trauma (referred to in this chapter as 'relevant information') with any other party who has a need to know, subject to privacy and confidentiality requirements. The default communication pathway is through the case manager
- participate in case conferencing forums
- keep complete and accurate records.

17 THE CRITICAL ROLE OF THE DEPARTMENTAL CASE MANAGER

The departmental case managers are assigned to persons who exhibit one or more risk indicators, including being in immigration detention and being a survivor of torture and trauma. They play a critical role in communicating and coordinating across functions both within and outside the department to ensure that application milestones are achieved and a person's wellbeing is looked after during the process. Case managers must be distinguished from the various "case officers" or "decision makers" who handle specific aspects of immigration processing.

The large number of parties involved in cases involving survivors of torture and trauma means that the risk of communication failures is significant, and the coordinating role of case managers is arguably the most significant mitigation for this risk. In performing this role, case managers have both responsibilities and needs. On the one hand, they have a responsibility to assertively seek out and pass on relevant information within privacy and confidentiality constraints; on the other, they have a need to know relevant information at the level required to properly manage a case. Other parties who come into possession of relevant information have an obligation to communicate this to the case manager.

See also section 28 Balancing the need for timely communication with privacy & confidentiality requirements.

18 SPECIFIC ROLES & RESPONSIBILITIES

HSM

- provide health assessments and services that are competent in identifying signs and symptoms of torture and trauma
- follow the referral pathways outlined in this policy
- notify the departmental case manager (or, where none has yet been assigned, departmental detention staff) where a person in detention is identified as a survivor of torture and trauma, subject to the individual's consent
- consider continuity of care for survivors of torture and trauma when conducting HDA
- maintain a network of community health providers with competence in recognising and responding to torture and trauma issues for persons in community detention.

Departmental case manager

- act as a communication and coordination hub, so that relevant information is communicated across functions and providers. In particular:
  - pass on relevant information from the HSM (or any other source) to any other party with a need to know. For example, notify a relevant visa decision maker when someone is identified as a survivor of torture and trauma so that relevance to any visa claims can be considered

  - feed relevant information into the detention review, client placement and status resolution processes
- ensure that the appropriate torture and trauma risk indicator is recorded for the person on departmental IT systems
- refer and actively pursue placement and status resolution outcomes by engaging relevant areas of the department and third parties
- ensure that all reasonable steps are taken to support survivors of torture and trauma in community detention
- if the person is being removed, liaise with departmental removal officers, the HSM and any other party to ensure that torture and trauma issues are factored into the planning and implementation of removals.

DSP

- communicate relevant information to departmental detention staff and the health service provider
- act on advice from the health service provider and department on the support of survivors of torture and trauma within an immigration detention facility.

Community detention external service providers

- coordinate with the HSM, the departmental case manager and Detention Health Operations Section to broker services for survivors of torture and trauma in community detention.

TORTURE AND TRAUMA RESPONSE PROCESS

This part comprises:

- section 19 Torture & trauma identification within the mental health screening process
- section 20 Detailed torture & trauma process
- section 21 Torture & trauma assessments on Christmas Island
- section 22 Managing cases where a person refuses referral to torture and trauma services
- section 23 Guidance on geo-political situations that trigger automatic trauma screening
- section 24 Appropriate forums for case conferencing
- section 25 Torture & trauma services for persons in the community
- section 26 Transition for persons granted a substantive visa or bridging visa
- section 27 Managing removals for survivors of torture & trauma.

19 TORTURE & TRAUMA IDENTIFICATION WITHIN THE MENTAL HEALTH SCREENING PROCESS

From a health screening perspective, the identification and support of survivors of torture and trauma commences at reception at an immigration detention facility and continues throughout an individual's period of detention, regardless of placement. It occurs within the framework of a larger mental health assessment process, which includes scheduled and triggered re-screening. This process is documented separately.

See also DSM - Chapter 6 - Detention health - Mental health screening.

Measures to identify and support survivors of torture and trauma that are built into the mental health screening and assessment process include:

- an HIA that is attuned to identifying signs and symptoms of torture and trauma
- a range of universal mental health screens designed to identify signs of distress, chosen for their cross-cultural validity and applicability to the mental health issues most relevant to persons entering immigration detention
- the Harvard Trauma Questionnaire (16 question short form):
  - as a triggered screen for persons identified during universal screening as symptomatic in ways suggesting a history of trauma
  - as an automatic screen for persons considered to be at high risk of having experienced torture and trauma
- referral for assessment by a FASSTT torture and trauma service where a person screens positive on the Harvard Trauma Questionnaire or, even in the absence of a positive screen, where there is a high index of suspicion.

Clinicians must use judgement when deciding whether or when to use the Harvard Trauma Questionnaire or other screening instruments.

See also section 29 The need for flexible application of this policy.

20 DETAILED TORTURE & TRAUMA PROCESS

Within the context of the comprehensive mental health screening and assessment process described above, the following table provides a generic four-stage process for the identification and support of survivors of torture and trauma. Implementation of the generic process may vary according to local arrangements for each region, facility or detention placement.

Stage	Who	Description
1. Identification of risk indicators	Health service provider, with input from any relevant source, including: on Christmas Island: ▪ Indian Ocean Territories Health Services (IOTHS) ▪ Australian Customs and Boarder Control Service ▪ entry screening teams ▪ departmental case manager ▪ departmental detention staff ▪ DSP ▪ refugee status assessment officers onshore: ▪ departmental Compliance ▪ Onshore protection decision makers (where a PV application has been made) ▪ departmental case manager ▪ departmental detention staff ▪ DSP ▪ Red Cross ▪ family ▪ friends ▪ advocates ▪ community contacts.	When a person enters immigration detention, contextualising information is drawn from a number of sources and fed into the induction health assessment. The nurse conducting the assessment is generally aware of this context and is alert for signs and symptoms indicating possible torture and trauma. On Christmas Island, the induction health assessment includes automatic referral for clinical interview by IOTHS, subject to the individual's consent. Identification of risk factors continues throughout the mental health screening process (next stage). Identification of risk factors can occur at any point during a person's period of immigration detention. If risk factors are identified at any point after initial health checks, the person should be referred for triggered mental health re-screening or immediate referral to a FASSTT torture and trauma service.

Stage	Who	Description
2. Comprehensive mental health assessment	Health service provider FASSTT	With the exception of IFFs and persons who remain in detention less than 7 days, persons entering an IDC or immigration transit accommodation undergo comprehensive mental health screening, including, where risk is identified, screening for torture and trauma. See also Mental health screening for people in immigration detention. Screening using the Harvard Trauma Questionnaire or, where appropriate, immediate referral for clinical interview by FASSTT will be offered to persons who: ▪ are symptomatic in ways suggesting a history of trauma ▪ disclose a trauma history ▪ come from geo-political situations where the experience of trauma is common See also section 23 Guidance on geo-political situations that trigger automatic trauma screening ▪ have made, or indicated that they intend to make, a substantive visa application. A positive screen on the Harvard Trauma Questionnaire, or a high index of suspicion even in the absence of a positive screen, triggers referral for specialist assessment by a FASSTT service. Where a person declines a FASSTT assessment, the process should continue with clinical input from the health service provider. See also section 22 Managing cases where a person refuses referral to torture and trauma services.

Stage	Who	Description
3. Review	Health service provider FASSTT departmental case manager departmental detention staff DSP Detention review unit AND… on Christmas Island: ▪ refugee status assessment officer onshore: ▪ departmental onshore protection case officer (where a PV application has been made)	Using a case conferencing approach, a review is conducted once a health provider indicates that they believe a person may be a survivor of torture and trauma. The departmental case manager assumes the primary coordination role until the person's immigration status is resolved. The purpose of this stage is to: ▪ review the assessment process and determine any additional requirements ▪ determine any immediate needs ▪ consider implications for client placement and detention review assessments. ▪ identify an approach to the development of a management plan, including the parties to be involved ▪ refer the case to an appropriate departmental area/s for consideration of an appropriate response in the particular circumstances. This may include grant of a bridging visa, preparation of a submission for Ministerial intervention seeking placement in community detention, or any other available status resolution option.

4. Development & implementation of a management plan	As for Stage 3
	
	AND…
	
	▪ any other community-based service provider, for example, Red Cross, community GP
	▪ if appropriate:
	  ▪ family
	  ▪ friends
	  ▪ advocates
	  ▪ community contacts.
		A management plan is developed and implemented, including:
		▪ accommodation, with a presumption of accommodation in the community
		▪ treatment, if appropriate
		▪ longer term management, with a focus on coordinating community-based supports (for example, ongoing treatment, legal assistance, social support)
		▪ transition to an appropriate departmental support service where a visa is granted - see section 25 Torture & trauma services for persons in the community
		▪ if removal is ultimately pursued, support arrangements during the removal operation and in the period following return to the home country - see section 27 Managing removals for survivors of torture & trauma.
		At an appropriate time, discharge planning should aim to ensure that any support required is continued in an appropriate form, regardless of immigration outcome.

Complex issues may arise at any point during this process, and may require escalation.

See also Dealing with complex issues.

21 TORTURE & TRAUMA ASSESSMENTS ON CHRISTMAS ISLAND

Due to the higher likelihood of torture and trauma among irregular Maritime arrivals, the IOTHS has been engaged under a memorandum of understanding (MOU) to provide torture and trauma services to persons in immigration detention.

22 MANAGING CASES WHERE A PERSON REFUSES REFERRAL TO TORTURE AND TRAUMA SERVICES

If a person declines referral to a torture and trauma service for assessment, the health service provider should emphasise to the person that the referral remains open and can be accessed at any time. If a clinician holds significant concern for a person's wellbeing in these circumstances, the clinician may need to advocate assertively on behalf of the person by escalating the case to the department for consideration of appropriate accommodation and status resolution options. In handling such cases, the health service provider may conduct its own assessments, but preferably with advice from the torture and trauma service.

23 GUIDANCE ON GEO-POLITICAL SITUATIONS THAT TRIGGER AUTOMATIC TRAUMA SCREENING

As described in Stage 3 of the above process, torture and trauma screening is automatically provided for all persons who come from geo-political situations where the experience of trauma is common (for example, persons from countries undergoing civil war or who claim to belong to a persecuted group). If in doubt, advice should be sought from Country Research Section, National Office.

24 APPROPRIATE FORUMS FOR CASE CONFERENCING

Stages 3 and 4 of the process described in section 20 Detailed torture & trauma process employ a case conferencing approach that seeks to engage the specific parties appropriate to a particular case. The reality for larger immigration detention facilities is that these discussions often occur as part of scheduled meetings designed to deal with a range of issues for several persons in detention (for example, client placement meetings). While such meetings may go some way to managing torture and trauma issues at the caseload level, they cannot be relied upon as the sole source of case conferencing because:

- not all parties present have a need to know detailed case information
- key parties cannot practically be involved and
- time constraints preclude an individually tailored approach.

The aim of such meetings should be to identify cases requiring individual case conferencing and then to ensure that this occurs.

25 TORTURE & TRAUMA SERVICES FOR PERSONS IN THE COMMUNITY

Although it is recognised that aspects of the environment in IDFs may act as health risk factors for survivors of torture and trauma, placement in community detention or grant of a bridging visa without adequate supports may in fact increase isolation and decrease access to services and supports. This section describes support arrangements for survivors of torture and trauma who are placed in the community while their immigration status is being resolved.

Persons in community detention

The Red Cross provides the primary support role for persons in community detention, and is responsible for brokering health and other support services. The Red Cross is monitored and assisted in this role by community detention liaison officers in each region and by Detention Health Operations Section, National Office.

Health services for persons in community detention are coordinated by the HSM, who is responsible for ensuring that its network of community-based health providers is equipped to cater for the special needs of persons who have experienced torture and trauma. Where possible, the HSM should attempt to preserve any therapeutic relationships developed prior to discharge from detention, for example with specific FASSTT counsellors.

26 TRANSITION FOR PERSONS GRANTED A SUBSTANTIVE VISA OR BRIDGING VISA

If a survivor of torture and trauma is released from immigration detention following the grant of a substantive visa or a bridging visa, the HSM should ensure a smooth transition to community with the offer of appropriate support. Subject to the individual's consent, the HDA for survivors of torture and trauma should include appropriate referrals so that any therapeutic relationships can be continued, should the person wish to do so.

Subject to the person's consent, any existing torture and trauma service provider providing specialist services to the person should also be notified that the person is no longer in immigration detention and may have relocated.

27 MANAGING REMOVALS FOR SURVIVORS OF TORTURE & TRAUMA

In some circumstances, a survivor of torture and trauma may exhaust all available options to remain in Australia and be subject to removal. In these circumstances, it is essential that the person's status as a survivor of torture and trauma be foremost in the minds of officers making decisions about the planning of the removal so that harm is avoided in the removal process and, where appropriate, supports can be arranged in the destination country. As far as possible, the case conferencing approach described in this instruction should be continued so that decisions regarding management of removals are made with maximum knowledge of the person's vulnerabilities and any protective factors which may assist in achieving the least traumatic removal possible within the circumstances. Case officers must be involved as early as possible in the removals planning process to ensure that any torture and trauma issues are identified.

DEALING WITH COMPLEX ISSUES

This part, which provides guidance on some complex issues that may arise in relation to survivors of torture and trauma that require special attention and, if necessary, escalation to senior management, comprises:

- section 28 Balancing the need for timely communication with privacy & confidentiality requirements
- section 29 The need for flexible application of this policy
- section 30 Escalation of complex issues.

28 BALANCING THE NEED FOR TIMELY COMMUNICATION WITH PRIVACY & CONFIDENTIALITY REQUIREMENTS

Timely communication is critical to the successful implementation of this policy. Tempering this is the need to respect privacy and confidentiality when communicating private health information. In most cases, this balance can be achieved by obtaining the individual's consent and sharing health information only at the level required to manage a particular case. Case managers often have a need to request information from clinicians about whether a person meets the definition of a survivor of torture and trauma for the purpose of health referral and therapeutic support (see section 11 Definition of a survivor of torture & trauma for the purpose of health referral & therapeutic support), the general nature of any related health issues, and any implications these may have on placement or status resolution options. Case managers and other non-health staff do not need to know detailed diagnoses or other clinical information of a highly personal nature.

Where non-health staff believe they have a need to access private health information beyond this level, requests are to be forwarded to the Detention Health Mailbox s. 47E(d) . In rare cases, a survivor of torture and trauma may expressly refuse consent for the clinician to pass on information about their status as a survivor of torture and trauma. Where this occurs, clinicians should seek advice from senior colleagues on how to balance their professional obligations. Legal advice on obligations under the Privacy Act 1988 may also need to be sought. Where any party believes that a rigid application of privacy and confidentiality requirements is creating a barrier to appropriate care, this should first be escalated through the Detention Health Mailbox and then, if unsuccessful, to senior management as described in section 30 Escalation of complex issues.

29 THE NEED FOR FLEXIBLE APPLICATION OF THIS POLICY

The highly variable experiences of survivors of torture and trauma and the very different detention environments onshore and on Christmas Island require a high degree of flexibility when undertaking torture and trauma assessments and response. Examples of this include the following:

- the mental health screening instruments prescribed for immigration detention, and the timings for conducting them, have been deliberately chosen for their suitability to the detention environment. However, clinicians must exercise clinical judgement to avoid unnecessary or potentially harmful screening processes. For example, where signs and symptoms of torture and trauma are obvious, clinicians should consider referring a person directly to a specialist torture and trauma service for clinical interview rather than screening using the Harvard Trauma Questionnaire
- where persons enter detention as groups, some may be more amenable to group interventions rather than individual counselling, while the opposite may be true for others. Similarly, assessment needs to take into account cultural differences and geo-political issues impacting on world-view and expectations. The Australian experience in the context of the IHSS has shown that some groups who may be highly traumatised may be better served by a number of group sessions aimed at building trust and "normalizing" common symptoms of post-traumatic stress, loss and relocation before any torture and trauma issues are even raised
- protective factors supporting a survivor may need to be preserved even if this means a departure from the letter of this policy. For example, where an individual's membership of a group is a protective factor, emphasis may need to be given to keeping the group together rather

than separating individuals in the name of expediting the individual's transfer to community detention.

Significant departures from this policy should be formally acknowledged by senior management, as described in section 30 Escalation of complex issues.

30 ESCALATION OF COMPLEX ISSUES

There will be cases for which this instruction does not provide adequate guidance, for example, where:

- identity and security checks may not be finalised as quickly as is desirable and persons with torture and trauma histories are at risk of being held in an IDF for extended periods of time
- trauma assessments and treatment recommendations under this policy cannot practically be provided by a FASSTT member
- a torture and trauma assessment by FASSTT does not provide adequate information to support a placement decision, such that a second opinion may be warranted
- departures from this policy are required to sensibly support someone with a history of torture
- there is concern that a rigid application of privacy and confidentiality requirements are creating a barrier to appropriate care.

In such circumstances, and where efforts to escalate the case locally have not been successful, the case should be escalated for resolution to:

- the Assistant Secretary, Detention Health Services Branch
- the Medical Director of IHMS
- (and where appropriate) the First Assistant Secretary, Compliance and Case Resolution Division.

Detention Services Manual
Chapter 6 - Detention health
Psychological support program (PSP)

ABOUT THIS INSTRUCTION

Contents

This instruction (known in the Detention Network as "Psychological Support Program (PSP) for the Prevention of Self Harm in Immigration Detention") sets out the policy on the psychological support program (PSP) for the prevention of self-harm in immigration detention. The instruction (and this policy) comprises:

- Introduction
- Overview of self harm risk
- Nine principles for the prevention & management of self harm
- Roles & team arrangements
- Psychological support program processes
- Levels of risk & response
- Supportive monitoring and engagement in the absence of a mental health clinician
- Self harm risk assessment interview.

Related instructions

- DSM Chapter 1 - Legislative & principles overview: Service delivery values.

Latest changes

Legislative

Nil.

Policy

This instruction, which is part of the centralised departmental instructions system (CDIS), was reissued on 15 May 2012.

Policy has been fully reviewed and updated with changes to section 26 24 hour limit on management of 'high imminent' self harm risk, section 27 Escalation of complex issues and section 29 Self harm prevention in community detention.

Owner

Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office.

Contents summary

INTRODUCTION

This part comprises:

- section 1 Purpose
- section 2 Who does this policy apply to
- section 3 Intended audience.

1 Purpose

The policy set out in this instruction aims to:

- provide a clinically recommended approach for the identification and support of persons in immigration detention who are at risk of self-harm and suicide, thereby reducing risk and improving health outcomes
- reduce the level of uncertainty and stress for staff in dealing with persons in immigration detention who exhibit self-harming and suicidal behaviour.

This policy acts as a basis for, but does not replace, in-depth training and operating procedures.

2 Who does this policy apply to

This policy applies to all persons in immigration detention, regardless of detention placement.

Although the principles contained in this policy apply to all forms of detention, the processes are tailored to immigration detention facilities. This not only recognises that some self-harm risk factors are more prevalent in more highly controlled detention environments, but also reflects the limited control available under community detention arrangements, which necessarily allow more freedom and less supervision. Limited guidance on the operation of this policy in community detention is provided at section 29 Self harm prevention in community detention.

3 Intended audience

The intended audience for this instruction is all staff who interact with, or advocate for, persons in immigration detention, including:

- The Department of Immigration and Citizenship (the department) including staff working:
  - at place of immigration detention and in policy roles
  - in case management, enforcement and policy roles and
  - state and territory office staff who interaction with persons in detention.
- The Detention Service Provider (DSP): the organisation contracted by the department to manage all operational and general welfare aspects of immigration detention facilities.
- The Health Services Manager (HSM): The health services organisation contracted by the department to facilitate access to health care for persons in immigration detention. The current HSM is International Health and Medical Services (IHMS).
- Health care provider: A health care professional, such as a general practitioner or registered nurse, engaged by the HSM to provide health care to persons in immigration detention.
- Community detention service providers: The providers contracted by the department to deliver primary community and welfare support to persons in community detention.

OVERVIEW OF SELF HARM RISK

This part comprises:

- section 4 Definition of self harm
- section 5 Distinguishing between self harm & suicide
- section 6 Risk factors for self harm & suicide
- section 7 Warning signs
- section 8 Protective factors
- section 9 Staff training.

4 Definition of self harm

For the purposes of this policy, suicide and self-harming behaviour is defined as "actions or threats of actions which, if carried out, may lead to self-injury or death".

Self-harming behaviours form a continuum ranging from indirect self-harming behaviour, to placing oneself in a physically dangerous situation, to suicidal thoughts, threats of suicide (verbal and non-verbal), non-accidental self-infliction of injury, attempted suicide and committing suicide.

Voluntary starvation (voluntary total fasting) can be viewed as self-harming behaviour; however, it will not be managed using this process unless a clinical assessment indicates that a psychological support program (PSP) intervention is appropriate.

5 Distinguishing between self harm & suicide

The literature on suicide indicates that it is notoriously difficult to distinguish between suicidal gestures (actions resembling suicide attempts while not being fully committed) and "genuine" suicide attempts (actions taken with intent to die). Although it is well established that self-harming behaviour frequently occurs in the absence of suicidal intent, it is equally true that the motivations of persons in deep distress can be impossible to know (even they may not be clear on their intentions) and that self-harm attempts not intending to cause death can result in serious harm or even unintentional death.

Research also suggests that deliberate self-harm is a major risk factor for future suicide. This does not mean that every person who self-harms will go on to make further self-harm or suicide attempts, but indicates that such persons should be considered 'at-risk' until further risk assessments can be made by a qualified clinician.

This policy does not attempt to provide guidance on the distinction between self-harm without suicidal intent and "genuine" suicide attempts but recognises that such judgments may be necessary for assessing the level of risk. Judgments of this nature will always be made by qualified clinicians.

6 Risk factors for self harm & suicide

Causes of self-harm and suicide are particularly complex. There are both exogenous (that is, factors outside of the individual) and endogenous factors (that is, factors within the individual) involved in the development of self-harmful behaviour. When the causes of self-harm are largely attributed to exogenous factors, as can be the case for some persons in immigration detention, individual interventions offer only limited effectiveness.

On the other hand, some of those who engage in self-harming behaviour come to detention with pre-existing vulnerabilities for which identification and accommodation is required.

Regardless of which factors might be involved in precipitating self-harming behaviour, it is possible to identify and help manage risks of self-harm and suicide among persons in detention.

This policy cannot provide a definitive list of risk factors for self-harm and suicide, and a more detailed exploration should be provided through training. Even then, it must be acknowledged that little research has been conducted on self-harm and suicide among persons in immigration detention, the existing evidence base coming from prison and community settings. Notwithstanding these limitations, it is possible to provide an overview of risk factors based on this research and advice from experts in the area of self-harm.

Generic risk factors include:

- history of self destructive behaviour (including deliberate self-harm)
- demographics (for example, being male, risk peaking at 23 years of age)
- behavioural traits (for example, impulsivity, poor problem solving, poor coping skills)
- long standing or recently diagnosed medical illness
- known psychiatric illness, particularly:
  - mood disorders
  - psychotic disorders
  - drug and alcohol disorders
  - past and current traumatic experiences, with or without a diagnosis for post-traumatic stress disorder (PTSD)
  - co-occurring mental illness and substance abuse
- significant loss (for example, bereavement)
- being a victim of criminal action, including physical or sexual assault and/or
- harm to, or self-harm in, friend / family member / close contact (including war or natural disasters in a person's home country).

Risk factors that may be more common for persons in immigration detention include:

- separation from family and significant others
- witnessing, or being involved in, group self-harming or destructive behaviours
- attempted or committed self-harm or suicide amongst others in detention
- distress associated with being detained, including significant fear of being returned to country of origin
- increased risk following visits
- increased risk following negative visa decisions and
- religious holidays.

7 Warning signs

A full appreciation of the range of potential warning signs is equally complex and should be explored in training. However, some of these may include:

- expressed feelings of guilt or shame
- emotional stress
- statements suggesting feelings of hopelessness or helplessness
- depression
- agitation
- social isolation or withdrawal
- threats or talk of suicide or self-harm and/or
- giving away many or all belongings.

8 Protective factors

A protective factor is any factor whose presence is associated with a reduced likelihood of a disease, condition or event. Protective factors enhance resilience and may serve to counterbalance risk factors. Although there is no specific research on protective factors for persons at risk of self-harm and suicide in immigration detention, protective factors for self-harm and suicide in the general community include:

- a significant other who listens and understands
- effective clinical care for mental, physical and substance use disorders
- easy access to a variety of clinical interventions and support for help-seeking
- restricted access to highly lethal means of suicide
- strong connections to family and community support
- support through ongoing medical and mental health care relationships
- skills in handling difficult emotions, problem solving, conflict resolution and non-violent handling of disputes and
- cultural and religious beliefs that discourage suicide and support self preservation.

Wherever possible, this policy seeks to strengthen these protective factors for all persons in immigration detention.

9 Staff training

All staff who work with persons in detention must be trained to recognise and respond to the warning signs and risk factors of self-harm and suicide.

Training should include:

- an awareness of the key risk and protective factors associated with self-destructive behaviour
- cultural awareness issues as they relate to mental state, expression of distress and self-harm
- recognising signs and symptoms and events that would trigger an evaluation (or re-evaluation) of risk
- routes and processes for referral to health services for those experiencing distress and
- PSP processes, including periodic updates as a result of continuous quality improvement.

Training for the DSP must also address the specific skills required to conduct self-harm risk assessment interviews at reception and to perform monitoring and engagement as described in this policy.

Training should be nationally consistent and delivered in an ongoing format (initial training and an annual refresher), with further, ongoing specialist support by the HSM and supervision by a senior independent mental health clinician. This may involve audits of knowledge and competence in the PSP process outlined in this policy.

NINE PRINCIPLES FOR THE PREVENTION & MANAGEMENT OF SELF HARM

10 Nine principles

The following nine principles underpin the prevention and management of self-harm for persons in immigration detention:

- A supportive environment
- Clinically-informed response
- A positive, supportive response
- Early identification of risk
- Response appropriate to the level of risk
- External referral in high risk cases
- Well trained and supported staff
- Cultural competence is critical
- Response must actively seek out and offer support to others who may be affected.

A supportive environment

The first priority in preventing self-harm is a focus on health promotion and prevention to reduce risk factors and strengthen protective factors in the immigration detention environment. The department's approach to this is outlined in:

- DSM Chapter 1 - Legislative & principles overview: Service delivery values
- the Detention Health Framework.

Providing a supportive detention environment to prevent self-harm is primarily the responsibility of the department and the DSP, with support from the HSM.

Clinically-informed response

Managing the risk of self-harm is everyone's responsibility and must be holistic and multidisciplinary.

Clinicians, on the basis of their training in mental health and self-harm management issues, determine the appropriate level of risk and response, including any other health issues relevant to the individual. However, in many cases the causes of self-harm risk and the best ways to address this are by non-health means and thus all service providers have a role to play in supporting and ensuring the safety of persons at risk of self-harm.

The HSM has a responsibility to proactively share appropriate information about self harm risk, and the DSP and the department have a responsibility to seek and act on clinical advice. Although there is a range of levels of expertise in mental health amongst different health professionals, all professionally trained clinicians have the capacity for effective risk assessment and exercise of informed judgment. This capacity needs to be based on education, training and peer review.

A positive, supportive response

It is important to safely care for those who are at risk for self-harm or suicide without further increasing their risk through excessive surveillance and scrutiny, which may actually increase distress and risk. It is imperative that the PSP is not primarily a defensive response. It is recognised that it is not possible to fully eliminate the risk of self-harm and that there the reasonable risks associated with a response that aims to support and reintegrate persons at risk of self-harm into the detention community as soon as possible rather than attempting to prevent self-harm at all costs.

Responses must recognise the basic human need for autonomy as well as safety, and this means generating strategies to enable autonomy for persons in immigration detention wherever possible. Even in secure environments risk cannot be eliminated completely, and calculated risks must sometimes be taken openly in discussion with all parties, and documented for the purposes of review.

Interventions for persons at risk of self-harm should emphasise:

- not “watching” but “being with”
- not “containing” but “maintaining support”
- not “isolating” but “integrating” and
- not “controlling” but “facilitating appropriate expressions of distress and anger”.

These are important changes in emphasis at a systemic level; they are not absolute prohibitions. Each case must be carefully assessed to seek an appropriate balance.

Underpinning the entire PSP process is the philosophy that staff are engaging in an ongoing process of getting to know each person in detention, all the time gathering knowledge and increasing their understanding of the evolving culture and dynamics in the individual detention facility.

Early identification of risk

Early identification of persons at risk of self harm and suicide is critical. Evidence from correctional environments indicates that half of all suicides occur within the first 24 hours following intake. However, the net for those perceived to be at risk must not be cast so broadly as to inaccurately identify many who do not in fact pose a real risk.

Response appropriate to the level of risk

Identification of risk must be followed promptly by a response that is proportionate to the level of risk. The starting point when a person appears to be experiencing emotional difficulty and self-harming or suicidal thoughts with low intent is a “kind ear” and encouragement. However, when a person is expressing or suspected of having suicidal thoughts with high intent, or is actively suicidal, close observation and more intensive, supportive engagement is essential.

External referral in high risk cases

Persons assessed as at High imminent risk of suicide or serious self-harm should be referred immediately for mental health assessment, including consideration of transfer to an external health service such as a hospital. Immigration detention facilities (IDFs) are not equipped, and must not be expected, to provide acute psychiatric care if there is a high imminent risk of self-harm.

See also section 20 Self harm risk levels and section 26 24 hour limit on management of ‘high imminent’ self harm risk.

Well trained and supported staff

Staff will be provided with the knowledge and skills to assist them in their early identification, intervention, monitoring and support roles. Skills development in relation to the prevention and management of self-harm should be embedded into routine practice and considered part of the core business of all staff working in IDFs.

See also section 9 Staff training.

Cultural competence is critical

An awareness and understanding of culture, cultural differences, and cultural manifestations of distress and mental disorder are central to identifying, supporting and eventually alleviating a person’s distress. This requires training in cultural competence and may also involve engaging assistance from those who have a specialist understanding of a person’s cultural and ethnic group. Interpreters, preferably onsite interpreters, must be used if language barriers are present.

Response must actively seek out and offer support to others who may be affected

If threats of self-harm and/or suicide lead to an action or attempted action it is vitally important to recognise the impact of this incident not only on the individual, but also on the wider community in, and possibly beyond, immigration detention. Services should adopt an inclusive policy that actively seeks out and identifies those close to the person involved in the primary incident, then also considers the wider peer group of that person. See also section 28 Post-incident response.

ROLES & TEAM ARRANGEMENTS

This part comprises:

- section 11 Generic roles & responsibilities
- section 12 Specific roles & responsibilities
- section 13 PSP team arrangements
- section 14 Privacy & confidentiality.

11 Generic roles & responsibilities

All parties are expected to:

- work together to provide an environment that seeks to prevent self-harm by reducing risk factors and enhancing protective factors, including activities and programs targeted at mental health promotion and prevention
- participate in PSP team meetings and processes, including case reviews and ongoing quality improvement
- keep complete and accurate records.

12 Specific roles & responsibilities

The roles and responsibilities of the department, DSP and the HSM are outlined below.

The department

- communicate with persons in detention about the progress of their case in a sensitive, supportive and coordinated manner
- collate incident reports relating to self-harm, and provide these as inputs to PSP quality improvement processes
- take responsibility for working with the DSP and the HSM to resolve systemic or ad hoc issues that threaten the effectiveness of self-harm prevention arrangements and
- conduct scheduled and triggered client placement assessments and detention review assessments.

DSP

- conduct initial self-harm risk assessment interviews (if appropriate) and refer persons at risk of self-harm to the HSM
- be alert to early warning signs and seek immediate advice from the HSM if risk of self-harm is suspected
- must follow clinical advice from the HSM
- engage with persons identified as at risk of self-harm in a supportive way
- record meaningful observations of persons on monitoring and engagement plans and ensure these are communicated to the PSP team
- respond to any attempted or committed self-harm or suicide incidents and submit incident reports to the department and
- ensure that responsibility for supporting persons at risk of self-harm is transferred effectively at shift changeovers.

HSM

- conduct initial and scheduled comprehensive mental health screening, as well as ad hoc assessments if an individual displays deterioration in their mental state or undergoes a significant change in their situation that may exacerbate distress
- develop and maintain therapeutic relationships with persons in immigration detention
- provide advice to the DSP about levels of risk and strategies for engaging and supporting persons at risk of self-harm
- seek out and use all collateral information when making assessments, providing care, and formulating advice regarding the management of persons at risk of self-harm

- refer persons for assessment by external health services if directed in this policy or if onsite support is unable to adequately cater for the mental health needs of person at risk of self-harm and
- with support from the PSP team, provide a coordinated post-incident response in the event of a serious self-harm incident, including written reports to the department on any triggers or contributing factors identified through post-incident debriefing

13 PSP team arrangements

The day to day management of cases involving risk of self-harm is undertaken by the PSP team, led by a senior clinician and supported by representatives from the DSP and the department.

A multi-disciplinary team approach is essential because, although decisions about the management of persons at risk of self-harm are led by clinicians, it is recognised that the DSP interacts most frequently with persons at risk of self-harm, and departmental staff may also have regular contact.

Although the PSP team should aim for consensus, the senior clinician leading the team may make unilateral decisions on issues such as levels of risk and response, including referrals for external assessment. The DSP and the department must act on clinical advice or, in highly contentious cases, escalate issues to senior management as per the arrangements described at section 27 Escalation of complex issues.

Membership of the PSP team is dependent on the circumstances of the case in question but would normally include:

- a senior clinician from the mental health team, who will act as the PSP team leader
- the DSP shift manager
- departmental staff on a need-to-know basis
  (the respective roles of case managers and detention services officers in cases involving self-harm risk is being clarified; whichever adopts the primary client support role will need to attend PSP team meetings) and
- (at the request of the PSP Team Leader) any person who may provide useful information and input, especially those who have had direct contact with the person at risk of self-harm.

In those rare cases where a member of the mental health team cannot attend PSP team meetings, the registered nurse must be present and, if necessary, a mental health professional consulted by telephone.

The PSP team will meet as often as required to guide the management of those cases where there is a risk of self-harm, noting that demand will vary depending on caseloads and between facilities. In a critical situation (meaning generally life threatening) the team would meet daily, or more frequently.

14 Privacy & confidentiality

The appropriate forum for detailed clinical discussions about health issues relating to persons at risk of self-harm is the clinical complex case meetings convened by the HSM. Non-clinical members of the PSP team do not normally need to know detailed diagnoses or other clinical information of a highly personal nature in order to successfully manage self harm risk. Instead, clinicians provide health summaries, risk assessments and management recommendations. In most cases, decisions about the level of private health information that can be shared in PSP meetings are made by the HSM in accordance with professional standards and its obligations under the Privacy Act 1988.

If non-health personnel believe they have a need to access private health information beyond the level provided by the HSM, requests are to be forwarded to the Detention Health Operations Section (National Office) at s. 47E(d)

If any party believes that a rigid application of privacy and confidentiality requirements is creating a barrier to appropriate care, this should first be escalated through the Detention Health Operations Section (National Office) and then, if unsuccessful, to senior management as described at section 27 Escalation of complex issues.

PSYCHOLOGICAL SUPPORT PROGRAM PROCESSES

This part comprises:

- section 15 PSP process in context
- section 16 PSP process in detail
- section 17 Initial self harm risk assessment
- section 18 Triggered reassessment of risk
- section 19 Supporting forms.

15 PSP process in context

The PSP process commences for all persons in immigration detention at reception and continues while a person remains in immigration detention. It occurs within the framework of a larger mental health assessment process, which includes scheduled and triggered re-screening. This process is documented separately.

See also PAM3: Act - DSM Chapter 6 - Mental health screening for persons in immigration detention.

The following table provides a high level overview of the PSP process, incorporating the mental health screening process (Stage 2).

	Stage	Who	Timing	Tool(s)/ Supporting Processes
1	Self-harm risk assessment on entry to immigration detention	DSP	On reception	Scripted Self harm risk assessment interview. See also section 17 Initial self harm risk assessment.
2	Comprehensive mental health screening and assessment	HSM or HCP (internal and external as indicated)	Initial mental health screening within 72 hours and full range of universal screening within 7 days, unless expedited due to identified risk	A range of screening and assessment tools and processes.
3	Management of self-harm risk under the PSP	PSP team	In response to identified risk of self harm on entry to immigration detention or at any point during a person's period of detention	▪ PSP monitoring and engagement plan ▪ PSP team meetings (multi-disciplinary) ▪ (clinical) Complex case meetings ▪ Other clinical records as appropriate.

16 PSP process in detail

The following table provides a detailed description of PSP process described in Stage 3 of the table in section 15 PSP process in context.

	Stage	Who	Description
1	Risk identified	DSP, HSM, the department, family, friends and/or advocates	Risk of self-harm is identified either through formal screening and assessment or via referral from any person concerned about self-harm risk in relation to a person in detention.

	Stage	Who	Description
2	Initiation of PSP	PSP team and DSP	Concerns are formally recorded, and the case is assigned to a PSP team. Is a clinician available to make an assessment of risk? ▪ If *Yes*, a clinician makes an assessment of the level of self harm risk. The process continues to Stage 3. See also section 20 Self harm risk levels ▪ If *No*, commence supportive monitoring and engagement and escalate to the DSP and departmental shift managers to determine if the person can be safely accommodated onsite until a clinician is available. Advice may be sought from a clinician by phone. Can the person be safely accommodated onsite until a clinician is available to conduct a risk assessment? ▪ If *yes*, a clinician makes an assessment of the level of self harm risk as soon as practicable. ▪ If *no*, arrange for the person to be transferred to a hospital. See also section 33 Process of supportive monitoring and engagement.
3	Ongoing Monitoring and Engagement as per the PSP	PSP team and DSP	Under the leadership of a senior clinician, the PSP team develops the monitoring and engagement plan appropriate for the identified level of risk. See also section 21 Monitoring & engagement plans Responses are adjusted to changing levels of risk.
4	Post-incident response (only in the event of a self harm incident)	HSM (particularly the mental health team) and DSP	If a self harm incident occurs, post-incident response arrangements are set in train. See also section 28 Post-incident response.
5	Scheduled reassessment of self harm risk	HSM	Self harm risk is reassessed as part of scheduled mental health re-screening arrangements or when triggered by risk factors or warning signs. See also section 18 Triggered reassessment of risk.

17 Initial self harm risk assessment

The DSP may conduct a self-harm risk assessment for persons entering immigration detention using the scripted interview at - see Self harm risk assessment interview. This process is optional and based primarily on individual client need and/or circumstances. In the interests of avoiding unnecessary and potentially intrusive screening processes, the DSP is entitled to rely on risk assessments conducted by health professionals if these can be or have been obtained on the day of arrival. This may be the case, for example, if one has already been performed by a health professional on a boat prior to landing on Christmas Island or if a health professional is onsite at an immigration detention facility and able to conduct an induction health assessment on the day of arrival.

DSP staff, through training in recognising signs and symptoms and events that would trigger an evaluation of self harm risk must nonetheless be alert for presentations that require referral to a health professional. Regardless of whether the DSP chooses to conduct or not to conduct the self-harm screening interview, the DSP must take reasonable steps to respond to concerning behaviours and document on the detainee's case file these and any action taken.

If the person being interviewed is not fluent in English, interpreting services must be arranged, preferably face-to-face. Staff conducting interviews must be carefully selected and trained to ensure that they have the aptitude and skills required to conduct interviews effectively. Observations recorded by the interviewer are provided to the registered nurse undertaking the induction health assessment or, if the assessment indicates a more serious risk, immediately to the mental health team or an emergency health service. The interview transcript, including any follow up action taken, be must be recorded in the client's case file.

The reception environment may be busy and unconducive to such a sensitive line of questioning. DSP officers undertaking these assessments must do everything possible to:

- conduct the assessment in an environment that is as private as possible
- adopt the demeanour of someone whose role is to help the person express themselves and reduce any distress they may be feeling about being detained and
- reassure the person that their safety and wellbeing is a personal responsibility of staff.

If the person's behaviour poses a serious risk to others, then minimising this risk must be the priority. The DSP is trained in de-escalation and should be aware that fear and distress can manifest as hostility, which may be amenable to de-escalation. The wording of the interview is aimed at achieving this to some extent. Health professionals, if available, should be engaged to assist with de-escalation strategies or even direct intervention if appropriate. Notwithstanding this, there may be situations where a person needs to be contained until they calm down. Such containment should wherever possible be undertaken with the input from the mental health team, be for the shortest possible time, and be well documented.

18 Triggered reassessment of risk

After the initial self-harm risk assessment and comprehensive mental health screening, it is vital to recognise that one or more of a list of events should trigger re-evaluation of this risk. Some of these events should automatically trigger re-evaluation of risk, whereas others indicate the need to use an informed judgment as to the need for re-evaluation.

Need for re-evaluation of risk status	Presenting factors
Automatic and absolute	▪ Negative visa outcome - primary or appeal ▪ upcoming removal or return to country of origin ▪ other significant set-backs with appeal progress ▪ harm to, or self-harm in, friend / family member / close contact and/or ▪ time: unless otherwise triggered, reassessment of self harm risk will occur during scheduled mental health re-screening as per the mental health screening process (at 6, 12 and 18 months, and 3-monthly thereafter). See also DSM Chapter 6 - Mental health screening for persons in immigration detention.

Need for re-evaluation of risk status	Presenting factors
Judgment required	Including (but not limited to): ▪ changes in sources of support (for example, separation from close family members) ▪ signs of changes in behaviour ▪ increased aggression ▪ withdrawal or social isolation ▪ signs and symptoms of depression ▪ threats and warning of self-harm and/or ▪ "contagion" (where one incident of self-harm or suicide attempt leads to a mass outbreak of self-harming or other protest behaviours).

Risk assessments are performed by the mental health team; however, a multidisciplinary response is particularly important to ensure that an assessment is triggered. The presenting factors listed above will not always be apparent to all parties. PSP team meetings therefore need to be forward looking in sharing of information about upcoming triggers if these are foreseeable. All parties outside of PSP meetings need to be alert to signs and communicate them as soon as possible to the PSP team.

19 Supporting forms

Supporting forms should be as few and as simple as possible. Monitoring and engagement plans should allow recording of meaningful observations rather than tick boxes. Arguably more important than written management plans are robust handover procedures to ensure that knowledge and responsibility are transferred effectively at the changeover of shifts.

LEVELS OF RISK & RESPONSE

This part comprises:

20 Self harm risk levels

There are three self-harm risk levels, depending on the severity and imminence of risk. The level of risk is determined by a member of the mental health team or another qualified mental health clinician following a face to face assessment. Broad guidelines for the assessment of each risk level are provided in the following table.

	Risk level	Assessment guidelines
1	**High imminent**	▪ For use where an individual has expressed clear plans to attempt serious self-harm or suicide, or where there is a high level of expressed intent, or where the person's level of psychological distress is so severe that clinicians believe there is a high risk of the same. ▪ A clinician considers that constant 1:1 monitoring and engagement is necessary to prevent serious self-harm or suicide. Note: Strict time limits apply to the use of high imminent risk of self-harm. See section 26 24 hour limit on management of 'high imminent' self harm risk.
2	**Moderate**	▪ For use where a person may have threatened self-harm or expressed ideas of hopelessness, but has not engaged in serious self-harming behaviour. ▪ A clinician believes that an increased level of scrutiny is warranted but that constant 1:1 monitoring would contribute to the level of distress.
3	**Ongoing**	▪ A person may have previously engaged in self-harming behaviour or has a pattern of threatening self-harm but is highly unlikely to have serious suicidal intent. The ongoing level may be used for persons who engage in non-lethal self-harming behaviour in the absence of known suicidal intent. ▪ A clinician believes that some level of observation is warranted but that intrusive monitoring and engagement would contribute to the level of disturbance.

Notes:

- The broad guidelines above are provided as a high level guide only. Health professionals are trained in assessment of risk and must use clinical judgment in each situation.

- In addition to the guidelines above, clinicians may move a person up or down through risk levels if there is improvement or deterioration in a person's mental state or intent to self-harm.

21 Monitoring & engagement plans

Monitoring and engagement plans are tailored to the level of risk. They are aimed at keeping the person safe and encouraging their reintegration with the wider community in immigration detention through a process of supportive monitoring and engagement.

The three levels of monitoring and engagement, from most to least intensive, are:

Constant - "arms length eye sight"

Constant monitoring and engagement is for persons at High imminent risk of self-harm or suicide. It requires constant one-on-one monitoring of, and engagement with, the individual in a safe and secure place with a minimum of written observations recorded every 30 minutes.

Despite the need for high levels of monitoring, staff should continue to consider ways in which contact with human supports and any other strategies may be used to enhance safety and encourage autonomy and reintegration.

The person should also be offered professional psychological support. It is not realistic or desirable for the primary support person to constantly "be with" and interact with a person whilst simultaneously recording observations.

For constant plans, a secondary support person (DSP or HSM staff member) should visit every 30 mins to make observations in a non-intrusive way by engaging both the primary support person and the person at risk of self-harm in conversation (assuming the person is awake). This helps to mitigate any risk that scrutiny is being used as behaviour management and protects staff against any allegations of this. It also provides the primary support person with opportunities for breaks from what is acknowledged to be a very draining role, and for both parties to temporarily 'disengage' (an analogy being the understandable wish to disengage from fellow passengers on a crowded long distant flight).

Note: Strict time limits apply to the use of constant monitoring and engagement. See section 26 24 hour limit on management of 'high imminent' self harm risk.

30 Minute

30 Minute monitoring and engagement is for persons at moderate risk of self-harm. It requires formally reported monitoring of, and engagement with, the individual once every 30 minutes at random times (meaning at not precisely the same times such as on the hour and half hour).

If the person is not immediately available at scheduled observation times, officers should locate and engage with them as soon as possible after 30 minutes. The person may need to be relocated to a safe environment to maximise their feeling of psychological support but they should be encouraged gradually to move out of the safe environment with appropriate support.

The focus of this level of monitoring and engagement is to encourage and to document attempts to reintegrate the person into the wider detention community. The support person should make enquiries about how the person is feeling and make offers that encourage a return to normal activities. Examples include getting a friend to visit, going outside, joining others for a meal, listening to music, reading a book. The person should also be offered professional psychological support.

Ongoing
Ongoing monitoring and engagement is for persons at ongoing risk of self-harm in circumstances where clinical judgment is that more intensive monitoring is unwarranted. It does not necessarily require specific placement but does require staff to be generally aware of the individual's circumstances and to record observations on three occasions during day shifts hours. The focus for this level of monitoring and engagement is to encourage normal behaviour and to document the level of social interaction, noting progress such as improvements or any signs of distress or deterioration.

22 Risk & response at a glance

The following table provides an at-a-glance view of risk levels and response, including timing of clinical reviews.

Risk level	Monitoring and engagement plan	Accommodation arrangements	Clinical review
High imminent	Constant - "arms length eye sight"	Secure, safe environment with supervised exercise and interaction with others	Every 12 hours, with assessment by an external mental health professional after 24 hours
Moderate	30 Minute	A secure, safe but less restrictive environment	Every 24 hours
Ongoing	Ongoing - general non-intrusive	Normal accommodation	Every 7 days

23 General guidelines for monitoring & engagement

Monitoring and engagement should emphasise:

- not "watching" but "being with"
- not "containing" but "maintaining support"
- not "isolating" but "integrating"
- not "controlling" but "facilitating appropriate expressions of distress and anger".

Written observations must be meaningful and recorded in detail, including details of the individual's mood, what they say, and their behaviours.

If possible, the person should be encouraged to maintain contact with outside social supports such as family, friends and cultural/religious figures if these are judged to be a protective factor - see section 5 Protective factors (this may not always be the case). Visits, phone calls, and recreation should be maintained, encouraged and supported.

Comprehensive handovers at changes of shift are critical. Incoming staff must be fully briefed and continue the monitoring and engagement plans developed by the PSP team. It is the responsibility of shift managers to ensure that plans are adhered to.

When choosing a primary support person, the DSP should take into account that there may be a good match or an existing relationship of trust that would maximise the effectiveness of monitoring and engagement. Female clients should be paired with a female primary support person.

Monitoring and engagement must be direct human-to-human contact. Observation via closed circuit TV (CCTV) may be important for evidentiary purposes but must never replace direct human contact.

24 Accommodation arrangements

As a general rule, unless the degree of risk necessitates accommodating an individual in a highly safe and secure environment, every effort should be made to accommodate them in their regular living environment in a way that does not draw undue attention to their situation. In some circumstances, it may be appropriate to relocate persons to a safer, but not highly secure, environment. Such accommodation should, as far as possible, retain a residential feel. Highly safe and secure environments are essential for persons at high imminent risk of self-harm.

Accommodation in a highly secure environment does not necessarily mean isolation. In fact, isolation should be avoided in all but the most extreme cases as research has shown that it significantly increases risk and, if isolation is perceived by persons in detention as an automatic consequence of disclosing distress, it may discourage honest communication of thoughts of suicide and self-harm. If segregation is ultimately indicated, supervision and human contact is essential.

Highly secure environments for persons at risk of self-harm should be free of hanging points, free of objects that can be smashed or broken to fashion a sharp implement and free of any shoelaces, drawstrings, ties, belts, long socks or any other material that could be used to fashion a noose. The removal of any items of clothing or personal items must be handled sensitively and explained as a measure to keep the person safe.

Persons requiring 30 Minute monitoring and engagement would normally be accommodated in a secure but less restricted environment and should be encouraged gradually to move out of the environment with appropriate support.

Persons requiring Ongoing monitoring and engagement would not normally have their movement restricted in any way.

It is acknowledged that not all immigration detention facilities have the infrastructure required to satisfy these guidelines. In such cases, the PSP team should seek to arrange the best fit possible within the constraints of the particular facility or seek offsite accommodation if appropriate.

All accommodation changes will be supported by a client placement assessment and adhere to the policy and procedures outlined in PAM3: Act - Compliance and Case Resolution - Case Management Handbook - Chapter 5 - Managing a case - Placement review.

25 Step-down from monitoring and engagement

Gradual removal of self-harm prevention responses should take place in a considered, managed and documented fashion, according to advice from the clinician leading the PSP Team.

26 24 hour limit on management of 'high imminent' self harm risk

A person who remains at high imminent risk of self-harm 24 hours after the initial assessment that they require constant monitoring and engagement, must be assessed by an independent mental health professional for consideration of ongoing risk of self-harm, including whether the person should be transferred to a community-based health service for further assessment.

This mental health professional should be someone who has not previously assessed the person for self-harm risk (in relation to the current assessment of self-harm risk), and may include a HSP mental health professional, a network provider engaged by the HSP or a clinician from a community-based health services, including a hospital.

Any person who remains at high imminent risk of self-harm for more than 24 hours should be reassessed, at a minimum, at every 24 hour interval. The person should also be reviewed by a General Practitioner if they require constant monitoring and engagement beyond a 48 hour period, or as soon as practicable after that time.

Any person who remains at high imminent risk of self-harm at 72 hours, is indicative of having a set of complex needs that cannot or should not be managed in the immigration detention environment. In such circumstances, the case must be escalated by the local HSM to the IHMS Medical Director, Mental Health Services. The departmental representative on the PSP team must also notify the relevant Health Liaison Officer and escalate the case to the Director, Detention Health Operations Section, National Office.

In parallel, there should be ongoing and well documented attempts to increase supports and offer strategies for reintegration of the person into the wider community in detention (for example, stepping up professional psychological support services, encouraging a phone call to lawyer, arranging for a friend to visit for an hour)."

27 Escalation of complex issues

There may be times when the PSP Team is unable to effectively manage a case in accordance with this policy. This may be because one or more parties is unwilling to proceed without seeking direction at a more senior level, or because the group encounters barriers to accessing care from the public health system. In these circumstances, the case should be escalated for resolution to:

- the Director, Detention Health Operations Section, National Office; and
- the Medical Director, Mental Health Services of IHMS.

28 Post-incident response

Post-incident response is critical to prevent harm extending to others in detention. In its worst form, the failure to actively diffuse the flow on effects of self-harm incidents can result in the so-called "contagion" effect, where one incident of self-harm or suicide attempt leads to an outbreak of self-harming or other protest behaviours.

The following table describes the four stage process that is followed in the event of a serious self-harm event. The PSP team leader determines which self-harm incidents are serious enough to warrant a post-incident response.

	Stage	Who	Description
	Pre-requisite: Awareness.	DSP, HSM, the department and external trainers.	Staff need to be made aware that self-harming activities can cause distress to others in detention - the so-called 'contagion' effect. This should be included in mandatory training on the prevention and management of self-harm.
1	Immediate response - communication.	DSP and HSM (particularly the mental health team).	Communicate what has happened to anyone who may have witnessed or been involved in the self-harm event in a way that provides reassuring messages, for example, 'X is being treated and cared for / has been taken to hospital'. If the self-harm is serious and the prognosis unknown, simply indicate that the person is being treated. Communication should continue for as long as the mental health team considers necessary.

	Stage	Who	Description
2	Post-incident response- debrief with individuals and offer support.	Mental health team.	Ask all staff to identify persons (including staff) who they think might be particularly affected, such as those who may have witnessed or been somehow involved in the self-harm event, or who may know the person. The mental health team should debrief with these persons. The aims are to: ▪ identify persons who are distressed ▪ offer support, including connection with services if appropriate ▪ help persons in detention see that self-harming is not a constructive course of action ▪ identify any triggers or contributing factors.
3	Post-incident response - debrief with wider community and offer support (optional).	Mental health team.	Debrief with the wider community to give accurate information, with the aim of preventing gossip. Offer support. The need for this type of debriefing should be determined with regard to the severity of the self-harm event and the extent to which news is likely to travel. It should be assumed that word of serious self-harm events will spread widely throughout an immigration detention facility. It is not necessary to disclose private health information to do this.
4	Report systemic issues to centre management.	HSM (particularly the mental health team), DSP and the department.	Any triggers or contributing factors identified through debriefing should be reported to centre management through incident reports and team meetings, and must be actively addressed as part of quality improvement processes.

29 Self harm prevention in community detention

Most persons in community detention will have undergone initial health screening at an immigration detention facility, including a number of measures design to identify risk of self-harm. If a person enters community detention without first passing through an immigration detention facility, health checks are performed by community-based health services coordinated by the HSM.

The support and services provided to persons in community detention are generally commensurate, but not above, support available to the broader Australia community.

The principles outlined in this policy apply to persons at risk of self-harm who are in community detention, however, such cases cannot be managed within the same processes as those in a detention facility. They may, however, be managed outside of formal PSP meetings using a more flexible case conferencing approach involving the various parties mentioned above.

The department has engaged a number of community detention service providers to provide care and welfare support to persons in community detention.

The community detention service providers are not expected to diagnose or assess any self-harm actions, threats or indicators as to their seriousness. This must be done by a mental health clinician. The duties of community service providers may however, place them in a position where they are likely to be made aware of these actions, threats or indicators.

Departmental case managers also have an important role in ensuring that reasonable measures are in place to ensure the wellbeing of persons in community detention while their immigration status is being resolved.

Health services for persons in community detention are coordinated by the HSM, who has responsibility for ensuring that health discharge arrangements include any appropriate health referrals, and that its network of community-based health providers are equipped to cater for the special needs of persons who may be at risk of self-harm.

30 Evaluation & quality improvement

The DSP is responsible for providing the department with formal incident reports on all threats, attempts or occurrences of self-harm and suicide.

If a serious self-harm attempt or incident occurs, the HSM has primary responsibility for post-incident response, one function of which is to identify triggers and contributing factors. The HSM must provide written documentation of these to the PSP team and the department for input to quality improvement processes.

The PSP team, with appropriate support from the department, is responsible for conducting regular case reviews and analysis of incident reports to identify issues that need to be addressed in order to improve self-harm prevention, identification and response arrangements. The adequacy of the arrangements documented in this policy should be a regular item for review as part of PSP quality improvement arrangements.

SUPPORTIVE MONITORING AND ENGAGEMENT IN THE ABSENCE OF A MENTAL HEALTH CLINICIAN

This part comprises:

31 About this part

This advice is intended to assist staff at places of immigration detention by providing guidance on implementing supporting monitoring and engagement with persons who are or may be at risk of self-harm and/or suicide when there is no mental health clinician immediately available to conduct an assessment of risk.

Supportive Monitoring and Engagement is an extension of the engagement that occurs on a daily basis between staff and persons in immigration detention. This includes the conversations and other interactions that occur as part of the relationship between persons who live and work at places of immigration detention. As the name suggests, supportive monitoring and engagement is a form of interaction that aims to support persons in immigration detention who may be vulnerable and in need of additional positive engagement to assist in a time of need.

32 Self-harm or suicide concerns

DSP and departmental staff are not expected to diagnose or assess self-harm actions, threats or indicators as to their seriousness. This must be done by a mental health clinician. The duties of the DSP and departmental staff may however, place them in a position where they are likely to be made aware of such actions, threats or indicators.

When self-harm or suicide concerns arise in the absence of a mental health clinician, DSP (and departmental staff, if appropriate) must immediately commence supportive monitoring and engagement and notify the HSM as soon as reasonably practicable.

As in any other situation where there are concerns about a person's physical health, the HSM should be requested to assess the person and advise on action in relation to treatment. This may include arranging for a person to be taken to hospital.

33 Process of supportive monitoring and engagement

Stage 2 in section 16 PSP process in detail outlines, in brief, the actions to be taken when a mental health clinician is not available to make as assessment of the person's self-harm risk level. If a clinician is not available to make an assessment of the level of self-harm risk, the following process is to be implemented:

Stage	Action
A	Departmental or DSP staff become are of self-harm or suicide concerns about a person at a time when the HSM mental health clinicians are not available to make an assessment of the person's level of risk under the PSP: ▪ In all situations, the DSP will commence supportive monitoring and engagement with the person until such time as a mental health clinician is available to make an assessment of the person's level of risk under this policy ▪ In a situation where concerns exist as to the physical health of the person (for example, from injuries) a clinician (for example, paramedic or alternatively the Nurse Triage Advice Service (NTAS)) should be advised so that an assessment can be made and advice given accordingly as to treatment for physical health concerns and ▪ As soon as reasonably practicable, DSP staff will contact, via the duty phone, DSP and departmental Shift Manager and/or Duty Staff in line with local PSP and Incident Reporting procedures.
B	The DSP and departmental Shift Managers and/or Duty Staff must escalate the issue, including consultations with clinicians (including non-mental health clinicians if appropriate) for example, paramedic or the NTAS in determining whether the person can be safely accommodated at the place of immigration detention and, if so, the appropriate level of supportive monitoring and engagement applicable to that person.
C	Supportive monitoring and engagement with the person will continue while advice is sought from the DSP and departmental Shift Managers and/or Duty Staff.
D	The HSM must be notified as soon as possible to arrange for a timely assessment by a mental health clinician. As soon as a mental health clinician is available to assess the person, DSP and department Duty Staff are to fully brief the clinician and act in accordance with the clinician's assessment of the person's level of risk.
E	Once a determination has been made by the DSP and departmental Duty Staff, in consultation with a clinician, as to: ▪ Appropriate accommodation and an appropriate supportive monitoring and engagement response for the person, DSP will continue with supportive monitoring and engagement until a mental health clinician is available on-site to conduct an assessment or ▪ The need for an immediate assessment of the person by a mental health clinician or the need to accommodate the person at a place other than the place of immigration detention- the DSP will arrange for immediate transport to hospital or equivalent setting for a clinical assessment.

If at any time the level of concern about a person changes prior to an assessment by a mental health clinician, the above process is to be repeated.

34 Appropriate supportive monitoring and engagement responses

Given that:

- the formal monitoring and engagement responses set out in section 21 Monitoring & engagement plans are to be implemented only after a person's risk level has been determined following an assessment by a mental health clinician and
- mental health clinicians are able to determine risk level only following a face-to-face assessment of the person about whom self-harm or suicide concerns exist

departmental and DSP staff are not able to make these determinations about risk level and response.

When a mental health clinician is not available however, supportive monitoring and engagement must commence. It is important to ensure that the supportive monitoring and engagement with a person is appropriate to that person's circumstances and that a 'one size fits all' approach is not adopted.

During the period of identification of self-harm and/or suicide concerns and the outcome of the escalation of these concerns to the DSP and departmental Shift Managers or Duty Staff, supportive monitoring and engagement should involve DSP staff being in the presence of the person of concern and:

- not simply "watching" or looking at a person, but engaging them through maintaining conversations, if appropriate
- ensuring that the person cannot harm themselves and/or others
- allowing the person to appropriately express their distress or anger and
- moving the person to an area within their place of immigration detention that will allow the above to occur. Caution must be taken in relation to moving a person from their usual accommodation.

Following the decisions made as a result of escalation to the departmental and DSP Shift Managers and/or Duty Staff, supportive monitoring and engagement will take the form most conducive to the safety of the person about whom self-harm and suicide concerns exist and:

- should maximise opportunities for personal contact, interaction and conversations, i.e. not relying on visual contact through CCTV or windows
- should not result in the person being isolated from others, including staff, by placement in an area without human contact
- should minimise to the greatest extend possible, the person being able to harm themselves or others and
- should engage with them, in the manner described above, not simply watching or looking at the person.

35 Determining whether safe accommodation is available when a clinician is not available to make an assessment

For the purposes of this advice, "safe accommodation" is defined as place that "is free from hurt, injury, danger and risk and involves no risk of mishap".

In determining whether a person can be suitably accommodated in their current place of immigration detention, departmental and DSP Shift Managers and/or Duty Staff should consult a clinician (including a non-mental health clinician, if appropriate) for example, paramedic or the NTAS.

These consultations should consider the accommodation available within the place of immigration detention, and whether the person should be transferred to a hospital for assessment and/or accommodation.

36 Is "safe accommodation" available

In considering whether a person can be safely accommodated within the place of immigration detention, DSP and departmental Shift Managers and/or Duty Staff will need to determine whether the usual accommodation area of the person, or any of the other available accommodation areas offer safe accommodation (per the definition above). In order to determine whether safe accommodation is available, the answers to the following questions must be "No":

- Do these areas have hanging points?
- Do these areas have easy access to large trees, stairways or other fixtures that might allow access to an upper floor or the roof?
- Can any of the following items be found in these areas:
  - Objects that can be smashed or broken to fashion a sharp implement?
  - Shoelaces, drawstrings, ties, belts, long socks, or material that could be used to fashion a noose?
  - Objects that could be ingested?

If "Yes", can any of these objects be replaced with similar but safer items? If so, the area may then offer safe accommodation.

37 Determining whether accommodation enables supportive monitoring and engagement

DSP and departmental Shift Managers and/or Duty Staff will need to determine whether supportive monitoring and engagement can occur with the place of immigration detention. In order to determine whether this can occur, the answers to the following questions must be "Yes":

- Can the person interact with other persons in immigration detention with relative freedom?
- Can the person be accommodated without being isolated from others, including the DSP staff providing supportive monitoring and engagement?
- Can the person be accommodated with minimal disruption from noise or disturbance from others
- Will the person be able to participate in their normal programs and activities?

38 Determining whether a person should be transferred to a hospital

Should it be found that safe accommodation is not available and/or the accommodation does not enable supportive monitoring and engagement to occur, then the person about whom there is self-harm or suicide concerns should be transferred to a hospital for assessment and accommodation. Similarly, if a clinician, including a paramedic or the NTAS recommends a transfer to hospital, this must occur.

39 Recording supportive monitoring and engagement decisions

It is important to differentiate a decision to begin the supportive monitoring and engagement with a person from a decision made under the formal PSP process, which can be made only by a mental health clinician.

When recording a decision to begin supportive monitoring and engagement on the department's CCMD portal, including in Incident Reports, DSP staff should include a free-text note advising that the decision was made in accordance with out of hours PSP procedures, and without the person being assessed by a mental health clinician at the time.

When providing information for inclusion in a departmental Detention Operations Situational Report (SitRep), staff should similarly make the distinction outlined above, with reference to out of hours PSP procedures.

SELF HARM RISK ASSESSMENT INTERVIEW

Hello, my name is [*name of officer*] and I am here to ask you a few routine questions about how you are feeling and if there is anything we need to do to help you feel comfortable right now.

A nurse will see you soon, probably on *[state probable day/time]*. They will talk to you and see if there is anything you need to manage your health.

I'm going to ask you a few questions about how you are feeling now. Try and answer them as honestly as possible. There are no right or wrong answers; they will just help me to understand if there is anything we can do for you.

I may need to take some notes while I talk to you.

1. Is it OK if I ask you a few questions now? If you do not want to continue at any time, just let me know, and I will stop.
   - If *Yes*, continue to question 2

- If *No*:

  I understand that this can be a stressful time for some people, and you do not have to answer these questions if you do not want to. But it is important for me to ask you these questions to ensure that I'm doing everything I can to help you. Is it OK to continue or would you like to have this discussion with the nurse?

  - If *OK*, proceed to question 2
  - If *Not OK*:
    Do you think that you need to see the nurse now?
    - If *Yes*, proceed to Scenario 1 of the Interview Wrap-up
    - If *No*, proceed to Scenario 2 of the Interview Wrap-up.

Note: *This boxed text should be used at any point in the interview if the person indicates that they do not wish to continue.*

2. Do you have any friends or family, in Australia or in any other country? Would you like us help you get in touch with them, or can we tell someone that you are here?

3. Have you ever experienced difficulties in managing your levels of stress, or times where you have felt overwhelmed by your emotions or unable to manage your emotions?
   - If *Yes*, on a scale of 1 to 10, with 10 being the most severe, how would you rate these difficulties? (Note the person's rating and go to question 4.)
   - If *No*, go to question 5.

4. Can you tell me about it, or would you prefer to talk to the nurse? If you are willing to tell me, then I will let the nurse know that you have had these difficulties.
   - If the person is *willing* to talk about it:

     Can you tell me about what happened?

     (Allow the person to answer in their own words.)

     Did you have any thoughts about harming yourself or about suicide at that time?

     (Listen attentively and supportively but do not press the person to talk about their self-harm or suicidal thoughts if they do not volunteer this information)
   - If the person is unwilling to talk about it:

     That's OK, I'll let the nurse know that you have had these problems.

5. Can you tell me how you are feeling now?

(Allow the person to answer in their own words)

6. Do you feel in control of your emotions now?
   - If *Yes*, continue.
   - If No:

     Are you having any thoughts about hurting or harming yourself now?
     - If *Yes*:

       Is there anything I can do to help now?
     - If *No*, continue.

7. This is my understanding of what you have told me [*summarise what the person has told you*]. Is that right?

8. Is there anything else that you think I need to know, or you would like to tell me?

(Proceed to Interview wrap-up)

Interview wrap-up

Scenario	If the person…	Then conclude…
1	has *refused to answer* the questions and *wants to see the nurse* immediately	OK, I will arrange for the nurse to see you as soon as possible. Until then (*explain the process of closer observation until the person sees a health professional*). Is that OK with you?
2	has *refused to answer* the questions and *does not want to see the nurse* immediately	I'm sorry that you do not feel that you can answer these questions at this time. If you change your mind, please let one of the staff know as we are keen to help you if you need it. The next thing that you will be doing is (*explain the next stages in the reception process*). *Note: Use judgment about whether the person needs closer monitoring and engagement.*
3	Has *no past or current difficulties*	Thank you for answering these questions. A nurse will see you on (*date, time*) to do a more thorough assessment of your health needs. The next thing that you will be doing (*explain the next stages in the reception process*).
4	has had *problems in the past*	Thank you for answering these questions. I understand that it can be difficult to talk about these things to someone that you don't know. It sounds as though you have had problems managing difficult or stressful situations in the past. I will let the health staff know this in case you need some additional support while you are here. If you feel that these problems are coming back while you are here, please let the staff know so that we can get help for you. The next thing that you will be doing (*explain the next stages in the reception process*).

Scenario	If the person…	Then conclude…
5	is *currently experiencing problems*	Thank you for answering these questions. I understand that it can be difficult to talk about these things to someone that you don't know, but we know that this can be a stressful time for people and we want to ensure that you are safe and receive any help that you need. Based on what you have told me, we will need to provide you with some extra support to keep you safe. The things that we will be doing are (*explain the process of closer observation and that you will alert a health professional*). Is that OK with you?

Notes:

- This interview process should not be attempted for a person who is obviously highly distressed or agitated. In such cases, refer the person immediately to a health professional and maintain close monitoring and engagement.
- An interpreter must be used if a person is not proficient in English, or requests an interpreter.
- This interview is designed to be delivered in an easy conversational style. However, without adequate training it is capable of being delivered as an impersonal set of questions that the interviewer has to get through to move on to the next stage in the reception process. Training is absolutely critical to ensure that interviewers deliver the interview in a way that engenders trust and elicits honest responses.
- The interviewer's goal is to help the person express themselves and to identify, resolve or reduce the distress associated with their human responses to being detained. An open questioning style will assist with helping the person express themselves.
- Staff conducting these interviews should carefully observe the person's level of distress. Even if they answer all questions in a way that appears to indicate they are feeling safe, certain signs (such as tone and volume of voice, mannerisms, posture, gait) may indicate that the person is distressed and should be referred for assessment by a health professional. Staff will need training in how to recognise signs of distress or hopelessness, and how to conduct interviews in a sensitive and supportive manner.
- Staff must follow through as soon as possible with any offers made to assist the person, or referrals for assessment by a health professional. Follow up actions should be recorded in the person's case file.
- If the person is aggressive or hostile, de-escalate the situation by asking essential questions only and responding appropriately to the situation. Give the person as much physical space as practicable. This will be covered by training.
- This interview seeks to collect information that could be important in identifying risk of self-harm. Collecting information is useful only if that information is acted upon. If the interviewer has any concerns for the person's safety, they should immediately take steps to obtain advice from a health professional. Interview transcripts must be provided to clinicians conducting health assessments.

Detention Services Manual
Chapter 6 - Detention health
Mental health screening

ABOUT THIS INSTRUCTION

Contents

This instruction comprises:

- Mental health screening
- Recommended core elements of a screening MSE
- Suggested learning objectives for MSE training in the immigration detention environment
- Cultural considerations during MSE.

Related instructions

- DSM - Chapter 6 - Detention health - Psychological support program (PSP)
- DSM - Chapter 6 - Detention health - Identification and support of survivors of torture and trauma
- DSM - Chapter 6 - Detention health - Mental health policies- Application to minors in immigration detention

Latest changes

Legislative

Nil.

Policy

This instruction, which is part of the centralised departmental instructions system (CDIS), was reissued on 1 July 2013 to:

- update the timing of the universal screening stage - see section 4.1 Mental health screening process description
- update the owner details (below) and
- make minor technical changes.

Owner

Stakeholder and Health Strategy Section
Detention Health Services Branch
Detention Infrastructure and Services Division
National Office.

Contents summary

MENTAL HEALTH SCREENING

1 Introduction and context

1.1 Purpose

The purpose of this instruction is to describe the mental health screening and assessment process for persons in immigration detention.

1.2 Background

In September 2005, the government announced enhanced mental health screening arrangements for persons in immigration detention, incorporating the following clinical processes and instruments:

- Mental state examination (MSE)
- Health of the Nation Outcomes Scale (HoNOS)
- Kessler 10 self report questionnaire.

Under these arrangements, all persons entering immigration detention (apart from illegal foreign fishers) were screened on entry and re-screened every three months or when otherwise indicated.

In 2007–08, the Mental Health Sub-Group (MHSG) of the Detention Health Advisory Group (DeHAG) reviewed mental health screening arrangements. It found that the measures in place had been useful in focusing the detention health system on the mental health needs of persons in detention. It also found, however, that with the exception of the MSE the tools used were not the most appropriate for the immigration detention environment.

The process described in this instruction reflects the revised approach recommended by the MHSG and endorsed by the DeHAG on 28 February 2008.

1.3 Definitions

Community detention external service providers: the providers contracted by the department to deliver primary community and welfare support to persons in community detention.

Department: the Department of Immigration and Citizenship.

Detention services provider (DSP): Organisation contracted by the department to manage all operational and general welfare aspects of immigration detention facilities.

Health care provider: A health care professional, such as a general practitioner (GP), registered nurse, or allied health professional engaged by the Health Services Manager to provide health care to persons in immigration detention.

Health induction assessment (HIA): An assessment of a person in detention to determine the person's health status, undertake shortly after being accommodated in a place of detention.

Health services manager (HSM): Health services organisation contracted by the department to facilitate access to health care for persons in immigration detention. The current HSM is International Health and Medical Services (IHMS).

1.4 Intended audience

The primary audience for this instruction is:

- the HSM
- health providers working in, or consulting to, immigration detention facilities and
- community-based health service providers engaged by the HSM for persons in community detention.

The main secondary audience is:

- departmental personnel working in policy and operational roles relating to detention, case management, compliance and onshore protection and
- the DSP.

1.5 To whom does the process apply

The mental health screening process described in this instruction applies to:

- persons entering immigration detention facilities

Exception: Illegal foreign fishers (IFFs) currently undergo a basic mental health screening during the health induction assessment and only those for whom mental health concerns are indicated proceed to a full mental health assessment.

- persons entering immigration transit accommodation (ITA) who are new to the detention services network.

All persons listed above undergo a screening MSE as part of the HIA; however, unless this identifies mental health presentations warranting further investigation, only those who remain in detention for more than seven days go on to receive comprehensive mental health screening.

1.6 To whom does the process not apply

The process does not apply to:

- IFFs and persons in an immigration detention facility for less than seven days, unless mental health issues are identified during the health induction assessment
- persons in an alternative place of detention (APOD) in the community
- persons in community detention and
- persons in immigration residential housing (IRH).

Health care for persons in an APOD, community detention or IRH is provided by a network of community-based health providers coordinated by the HSM. The HSM is responsible for ensuring that its network of community-based health providers is equipped to cater for the special needs of persons in immigration detention, including persons with mental illness, persons who have experienced torture and trauma and persons at risk of self-harm. These health providers are not obliged to adopt the tools or processes described in this instruction, though they may wish to do so.

2 Purpose and principles of screening

2.1 Purpose of mental health screening and assessment

The mental health screening and assessment process serves slightly different purposes at induction and subsequently during a person's period of immigration detention.

At induction, it:

- records a baseline mental health assessment
- identifies persons with mental health problems who may need attention or treatment during their period of immigration detention
- provides a basis for the development of treatment plans.

At prescribed intervals, or when subsequently triggered by referral, it:

- seeks to identify persons for whom previous screening resulted in false negatives and persons who may have developed mental health problems while in immigration detention
- collects data to monitor an individual's mental health status over time.

2.2 Principles for selecting and using mental health screening tools

In selecting and using mental health screening tools, the MHSG identified the following principles:

- Avoid multiple, intrusive screens.
- Be clear about what is being screened for and why.
- Health screening is offered but not imposed.
- Use clinical judgement when deciding whether to use screening instruments. In certain situations, direct referral for clinical assessment may be appropriate where individuals could be unnecessarily distressed by screening procedures.
- Embed tools within a process. They do not replace judgement and an ongoing focus on cultural issues.

- No tools have been adequately validated for culturally and linguistically diverse (CALD) groups, so monitoring will be important.
- Screening for risk of self-harm should be integrated into the larger mental health screening process.
- Screening tools are for flagging the need for clinical investigation and for trend analysis, not for diagnosis.

3 Screening instruments and assessments

3.1 Mental state examination (MSE)

Of the mental health screening tools introduced in 2005, the MHSG recommended continuing the use of the MSE with some important qualifications:

- It should be referred to as a "screening MSE" when conducted by a registered nurse or mental health nurse. The term "screening" is used deliberately to acknowledge that an MSE conducted by registered nurses or mental health nurses can flag issues for further investigation but does not result in a diagnosis.
- A screening MSE should be conducted twice, once during the HIA and again as part of the seven day comprehensive mental health screen. This is considered appropriate, as new information and observations may have arisen over the intervening period, resulting in a more accurate assessment.
- The MSE pro forma should include certain mandatory elements described in the Recommended core elements of a screening MSE.
- Standard training for registered nurses includes some basic competency in the conduct of an MSE. However, it does not equip them to conduct an MSE in the complex cross cultural detention environment. Registered nurses and others who conduct screening MSEs should be trained at commencement of work in the detention environment, and retrained periodically to ensure they maintain competencies. See
  - Suggested learning objectives for MSE training in the immigration detention environment and
  - Cultural considerations during MSE.

3.2 General Health Questionnaire (GHQ30)

The GHQ30 was chosen because it:

- indicates subjective distress
- is not overly specific
- has good reliability, including some level of cross cultural validity
- presents no difficulties in scoring
- does not require a high level of training
- is available at no cost.

The time required to conduct the GHQ30 is 8–10 minutes, or about 15–20 minutes when using a translator. A cut-off score of 4/5 (recommended by Goldberg D.P et al, 1997) should be used initially and reviewed after six months. A delay of seven days for administration of the GHQ recognises that the instrument is designed to capture differences between a person's current and "usual" mental state and is therefore sensitive to changes in a person's environment. Given that persons entering detention have often undergone a dramatic change in environment, earlier use is likely to result in invalid results.

3.3 Depression Anxiety Stress Scales (DASS-21)

The DASS-21 was chosen because:

- it is a reliable and valid instrument for the detection of depression and anxiety
- depression, anxiety and somatic symptoms are the most common mental health complaints for persons in immigration detention
- it has been used with several different population groups.

3.4 Harvard Trauma Questionnaire

The Harvard Trauma Questionnaire (16-question short form by Richard F. Mollica, 1991) was chosen because it:

- has been used extensively in traumatised populations
- has been used with many different cultural groups.

3.5 Health induction assessment (HIA)

An HIA is conducted for every person in immigration detention (who consents) and is generally the first time a person sees a health professional following entry to immigration detention. It presents a critical opportunity to identify and respond early to health (including mental health) issues. The HSM will complete a HIA as soon as possible, but in all cases within three days (that is, 72 hours) of the person entering immigration detention (unless the person declines). Relevant health risk factors may require an immediate response, which will be facilitated by the HSM.

The HIA includes a screening MSE incorporating the elements described in the Recommended core elements of a screening MSE.

For further information, refer to DSM - Chapter 6 - Detention health – Health Induction Assessment.

3.6 Self-harm risk assessment interview

Screening for risk of self-harm may be conducted by the detention services provider (DSP) during the reception process, prior to any health screening. To support this, the DeHAG MHSG has developed a conversational style self-harm risk assessment interview specifically for use by non-health professionals in the detention environment. See also section 4.7 Identifying persons at risk of self-harm.

4 Mental health screening process

4.1 Mental health screening process description

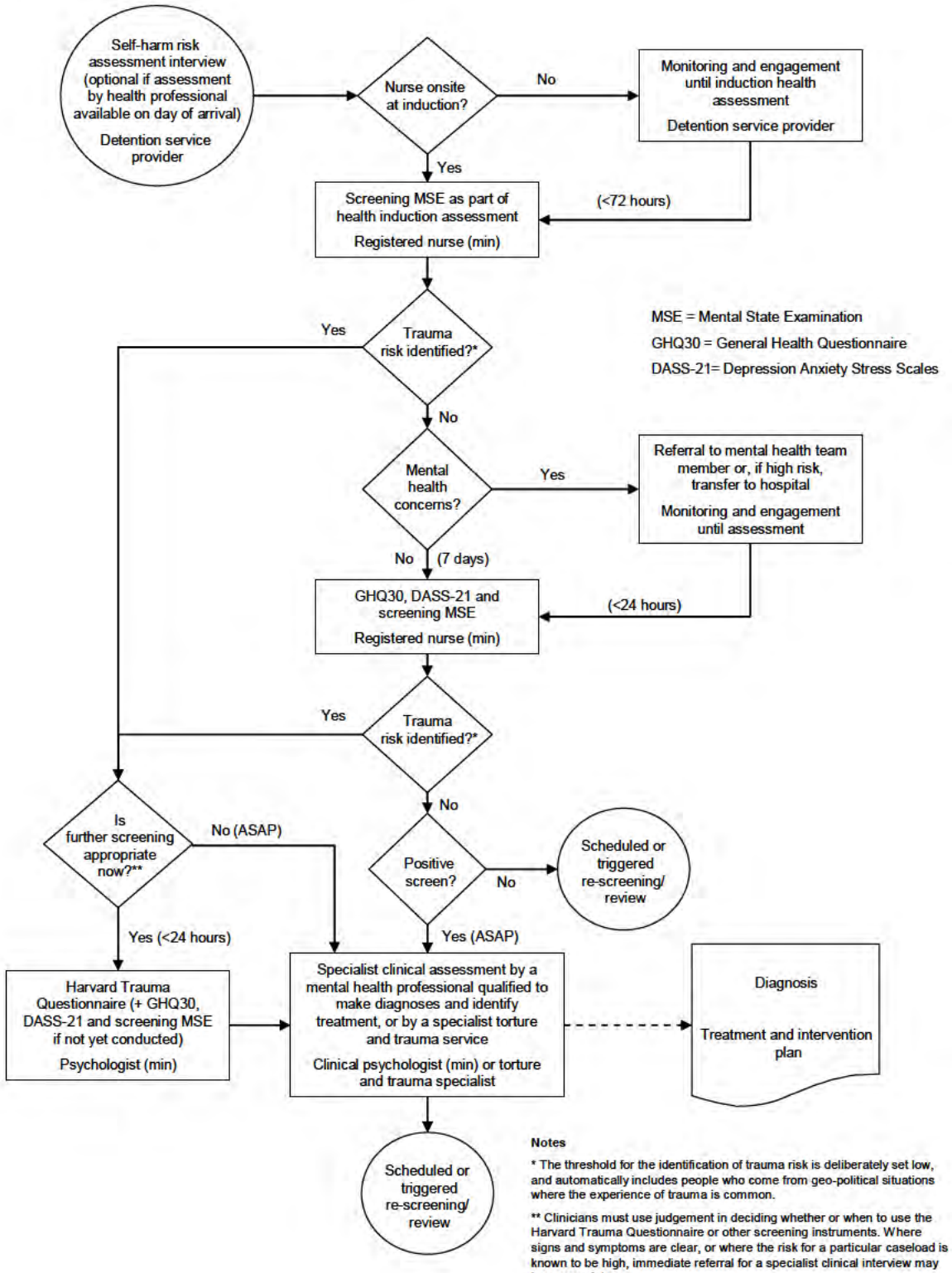
The following table shows the screening and assessment process used for persons in immigration detention. This may be preceded by a self-harm risk assessment conducted by the DSP. See also section 4.7 Identifying persons at risk of self-harm.

Stage	Who *	Timing	Process/Tool(s)
1. Health induction assessment	Registered nurse (min)	On reception or within 72 hours	Screening MSE conducted as part of health induction assessment
2. Universal screening (excluding IFFs)	Registered nurse (min)	At 10 - 30 days after arrival	▪ Screening MSE ▪ General Health Questionnaire (GHQ30) ▪ Depression Anxiety Stress Scales (DASS-21)
3. Indicated screening	Psychologist (min)	<24 hours, only if indicated	Harvard Trauma Questionnaire

Stage	Who *	Timing	Process/Tool(s)
4. Specialist clinical assessment	Clinical psychologist (min)	ASAP, only if indicated	Clinical assessment, including full MSE, leading to diagnosis and development of a treatment and intervention plan. The nature of specialist clinical assessments will vary depending on the nature of the problem. Torture and trauma counselling will be provided by a specialist torture and trauma service.
5. Scheduled or triggered re-screening	Various, depending on instruments and assessments used	At 6, 12 and 18 months, and then 3-monthly thereafter OR when concerns are raised about a person's mental health OR after bad news or other potential triggers	Various options as described at 4.4 (Scheduled re-screening) and 4.5 (Triggered re-screening). Note: A comprehensive psychiatric assessment by an external psychiatrist is undertaken for all persons who remain in detention for 18 months.

* The "Who" column contains minimum qualifications required to perform screens and assessments. In practice, these may be performed by more staff that are qualified where available.

4.2 Mental health screening process flowchart



4.3 Exceptions to the standard process

Screening at stages 3 and 4 is generally dependent on a positive screen at stage 2, with the following important exceptions:

- Automatic stage 3 screening in certain circumstances
  In certain circumstances it will be appropriate to automatically screen persons at stage 3 regardless of whether they screen positive at stage 2, for example, where they have arrived from geo-political situations known to be high risk for torture and trauma. See also 4.6 (Identifying survivors of torture and trauma).
- High index of suspicion is a valid flag for screening at stages 3 and 4
  Clinicians must have the freedom to respond to "gut feelings" and request screening at stages 3 and 4 even where someone screens negative at an earlier stage. Persons with mental illness, particularly psychosis, can sometimes be very good at answering screens in a way that results in a false negative and there is evidence that some torture and trauma survivors hide their experience as a survival mechanism.

4.4 Scheduled re-screening

Scheduled re-screening serves two purposes:

1. to identify persons for whom earlier screening returned a false negative or those who may have developed mental health problems while in immigration detention
2. for individuals who have previously screened positive, it collects data to monitor mental health status over time.

Scheduled re-screening will occur at 6 months, 12 months, 18 months and then 3-monthly thereafter.

At 18 months, there will be a mandatory comprehensive assessment by a psychiatrist.

At 6 and 12 months, scheduled re-screening should include the screening MSE, GHQ30 and DASS-21, and should be carried out by a registered nurse (minimum).

Where mental health problems have been previously identified for an individual, scheduled re-screening should ideally be carried out by a clinical psychologist, psychiatrist or other mental health professional qualified to make a diagnosis.

4.5 Triggered re-screening

Any concern raised about a person's mental health by friends, family, advocates, legal representatives, others in detention, health personnel, departmental staff or DSP staff should trigger re-screening or specialist clinical assessment at any time following induction, especially after rapport and trust is established with staff. Triggered re-screening may also be carried out following the receipt of bad news or other stressful events.

Clinical judgement should determine whether to re-administer the GHQ30, DASS-21 and Harvard Trauma Questionnaire. If concerns arise about the mental health of a person who has screened negative using any screening instrument within the previous two months, consideration should be given to moving directly to specialist clinical assessment by a mental health professional.

4.6 Identifying survivors of torture and trauma

Measures to identify and support survivors of torture and trauma are built into the mental health screening and assessment process outlined in this instruction.

Features include:

- a HIA that is attuned to identifying signs and symptoms of torture and trauma
- a range of universal mental health screens designed to identify signs of distress, chosen for their cross-cultural validity and applicability to the mental health issues most relevant to persons entering immigration detention
- the Harvard Trauma Questionnaire (16 question short form):

  - as a triggered screen for persons identified during universal screening as symptomatic in ways suggesting a history of trauma
  - as an automatic screen for persons considered to be at high risk of having experienced torture and trauma
- referral for assessment by a specialist Torture and trauma service provider where a person screens positive on the Harvard Trauma Questionnaire or, even in the absence of a positive screen, where there is a high index of suspicion.

Full details of arrangements for the identification and support of survivors of torture and trauma are in DSM - Chapter 6 - Detention health - Identification and support of survivors of torture and trauma.

4.7 Identifying persons at risk of self-harm

The screening MSEs conducted during the health induction assessment and again at 10 - 30 days by the Mental Health Team incorporate a self-harm risk assessment.

Screening for risk of self-harm may also be conducted by the DSP during the reception process, prior to any health screening. The DSP uses a conversational style self-harm risk assessment interview developed specifically for use by non-health professionals in the detention environment.

This process is optional and based primarily on individual client need and/or circumstances. In the interests of avoiding unnecessary and potentially intrusive screening processes, the DSP is entitled to rely on risk assessments conducted by health professionals where these can be or have been obtained on the day of arrival. This may be the case, for example, where one has already been performed by a health professional on a boat prior to landing on Christmas Island or where a health professional is onsite at an immigration detention facility and able to conduct an HIA on the day of arrival.

The text of the self-harm risk assessment interview and full details of self-harm prevention arrangements are in DSM - Chapter 6 - Detention health - Psychological support program (PSP).

4.8 Monitoring and evaluation of these arrangements

Monitoring and evaluation of these arrangements will be essential, as no instruments have been validated for use in the detention environment. Monitoring and evaluation will be heavily reliant on the capture and analysis of sound data on:

- scores for screening instruments: totals, and if the instrument has sub-scales, the sub-scale scores
- prescription of psychotropic medications
- self-harm incidents
- psychiatric admissions
- external specialist examinations/reviews (including for complaints, which may be psychosomatic, such as irritable bowel).

RECOMMENDED CORE ELEMENTS OF A SCREENING MSE

Assessment

Appearance	racial origin; attire, general physical condition; cleanliness; posture (sitting and/or standing) and gait
Behaviour	facial expression; relaxed or cooperative or aggressive; describe in detail activity, agitation, level of arousal (including physiological signs), eye contact, appropriateness of behaviour
Speech Mood	form and pattern; language spoken, volume and rate; is it coherent, logical, and congruent with questioning? unconcerned, irritable, labile; optimistic or pessimistic; thoughts of suicide; do reported experience and observable mood agree?
Risk	thoughts of suicide or deliberate self-harm. Thoughts of harm to others
Thought	particular preoccupations; ideas and beliefs; are they rational, fixed, or delusional? Do they concern the safety of the person or other people? Do they relate to the person's attire, speech or mood and if so, how?
Perception	abnormalities including hallucinations occurring in any modality (auditory, visual, smell, taste, touch)
Insight	how does the person explain or attribute his or her symptoms or experiences? What is the person's understanding of the factors contributing to their current situation? How the person perceives her/his need for care and/or treatment and support?
Medical/physical	medication, sleep, appetite
Trauma/torture	past and present

Risk assessment

Plan

Need for further assessment:
Referral:
Safety concerns:
Degree of urgency

SUGGESTED LEARNING OBJECTIVES FOR MSE TRAINING IN THE IMMIGRATION DETENTION ENVIRONMENT

The aim of an education and training session should be to:

- develop skills in environmental assessment specific to the immigration detention environment
- critically evaluate multiple factors that affect mental health outcomes for persons in immigration detention
- identify and describe key terms related to MSE
- identify the importance of undertaking a MSE for persons of diverse cultural and linguistic background within immigration detention
- identify essential interviewing and observation skills required for the assessment process
- gain knowledge in documentation and communication of relevant data
- discuss interventions appropriate to persons with mental health problems in immigration detention
- identify appropriate mental health outcome measures for use in the detention environment.

Material presented should assist participants to extend their scope of practice in the areas of mental health assessment, environmental analysis, documentation and positive interventions for persons in the detention environment.

These learning objectives were prepared by Associate Professor Nicholas Procter and endorsed by the Mental Health Sub-Group on 15 February 2008.

CULTURAL CONSIDERATIONS DURING MSE

The following excerpt is adapted from Procter, N.G. (2007) Mental health emergencies, in K. Curtis, C. Ramsden and J. Friendship (Eds), Emergency and Trauma Nursing, Elsevier Press: New York.

Mental State Examination

The Mental State Examination (Table 1) is designed to obtain information about specific aspects of the individual's mental experiences and behaviour at the time of interview. Examination can be based upon one or two interviews or developed from data generated over a period of time. This may be through interactions and involve information from relatives and friends.

Cultural and language issues

'Culture' gives people meaning and context to the way they communicate thinking, action and events. 'Culture' also allows people to make assumptions about social and emotional life, illness and death and how they should be understood within a particular context or setting. When individuals from one culture find themselves living in a different cultural context there may be differences in the way that they communicate idioms of distress and suffering. In mental state examination it is important to look beyond taken-for-granted assumptions regarding the way that symptoms of mental distress are communicated and the personal meaning that people from culturally and linguistically diverse cultures give to their experience. For this reason, people from culturally and linguistically diverse backgrounds remain a population group requiring special attention to their mental health status.

The challenges of a diverse population—of developing a culturally inclusive mental state examination remain.

Below are some cultural and language considerations relevant to mental state examination:

- It is not uncommon for stress to increase the likelihood that a person from a culturally and linguistically diverse culture may revert to their language of origin.
- Be aware that a prior relationship between the person and an interpreter can be a problem in small ethnic groups—in particular new and emerging communities—where there tend to be fewer accredited interpreters.
- Cultural differences can result in markedly variable mental health presentations. Cultural differences can influence the way in which symptoms are presented, what is considered a good outcome, acceptance of involvement from health professionals (if required) and help seeking behaviour more generally.

When providing health services to persons from culturally and linguistically diverse backgrounds it is important to communicate clearly. Wherever possible, they should be able to use their preferred language, especially in stressful situations. If the person requests an interpreter or has inadequate language skills, a professional interpreter should be used except in emergency situations. The following tips adapted from Multicultural Mental Health Australia

> [Language Competency Tips. Multicultural Mental Health Australia, 2004. Available from URL http://www.mmha.org.au Accessed 29 January 2008.]

will help discover how well and to what extent a person speaks and understands English.

- Ask questions the person has to answer in a sentence. Avoid questions that can be answered by 'yes' or 'no'. What? Why? How? When? questions are usually best as they allow for an 'opening-up' and expression and ideas.
- Ask the person to repeat in their own words some information you have just given them.

If the person cannot answer the questions easily, or can't repeat back information accurately, use a professional interpreter. When working across cultures it is important to remember that:

- asking the person their name, address, date or birth and other predictable information is not an adequate test of English language skills.
- their having social conversation skills in English does not always mean a person understands complex information in spoken or written English.

Oral communication skills do not always equate with reading and writing skills. Remember the need to tell the person their rights and get informed consent.

As previously mentioned, a person may lose their second language skills in stressful situations, for example, when talking about mental health problems or seeking help.

Table 1: Important items for mental state examination

Appearance	racial origin; attire, general physical condition; cleanliness; posture (sitting and/or standing) and gait
Behaviour	facial expression; relaxed or cooperative or aggressive; describe in detail activity, agitation, level of arousal (including physiological signs), eye contact, appropriateness of behaviour
Speech	form and pattern; language spoken, volume and rate, is it coherent, logical, and congruent with questioning?
Mood	unconcerned, irritable, labile; optimistic or pessimistic; thoughts of suicide; do reported experience and observable mood agree?
Risk	thoughts of suicide or deliberate self-harm. Thoughts of harm to others
Thought	particular preoccupations; ideas and beliefs; are they rational, fixed, or delusional? Do they concern the safety of the person or other people? Do they relate to the person's attire, speech or mood and if so, how?
Perception	abnormalities including hallucinations occurring in any modality (auditory, visual, smell, taste, touch)
Insight	how does the person explain or attribute his or her symptoms or experiences? What is the person's understanding of the factors contributing to their current situation? How the person perceives her/his need for care and/or treatment and support?
The full mental state examination may be built up over several interviews by elaboration of these topics using increasingly direct, closed questioning, as well as collateral information provided by friends and family members. It is helpful to report the person's experiences and symptoms word-for-word.	

Crucial to the practice of effective mental state examination is the way that an assessment is communicated, the way in which symptoms are described and the language used by both practitioners and person in this process. The formulation of a succinct summary of a person's history, current circumstances, and main problems will help set a considered response in context. It is particularly useful in conveying essential information upon referral for specialist assessment, or a referral for other specialist intervention. The time and trouble taken to communicate assessment findings will go a long way to helping ensure continuity of information and, if more than one provider is involved, continuity of the therapeutic relationship and ensure timely referral for additional assessment and/or care (Table 2).

Table 2: Important items for referral to additional services

- Description of the presenting complaint, its intensity and duration.
- Relevant current and past medical history and medication.
- Notes from mental state examination, highlighting key or contradictory findings.
- Estimate of degree of urgency in terms of risk to the person and others.
- Indication of referrer's expectations (assessment, advice, admission).

The most urgent requests should be reinforced by telephone or email.

Clinical engagement and cultural competence

Active engagement with people to achieve cultural competence will depend upon the practitioner's openness and flexibility around cultural awareness. The cultural awareness questions listed below are adapted from Multicultural Mental Health Australia's Cultural Awareness Tool

> [Cultural Awareness Questions. Multicultural Mental Health Australia, 2004. Available from URL http://www.mmha.org.au
> Accessed 29 January 2008.]

and designed to help practitioners respond to people in the context of their mental health problems and/or mental ill health:

- Can you tell me about what brought you here? What do you call _____ (use the person's words for their problem)?
- When do you think it started, and why did it start then?
- What are the main problems it is causing you?
- What have you done to try and stop/manage _____ to make it go away or make it better?
- How would you usually manage _____ in your own culture to make it go away or make it better?
- How have you been coping so far with _____?
- In your culture, is your _____ considered 'severe'? What is the worst problem _____ could cause you?
- What type of help would you be expecting from me/our service?
- Are there people in your community who are aware that you have this condition? What do they think or believe caused _____? Are they doing anything to help you?

Conclusion

Mental state examination across cultures requires practitioners to understand the concept of culture, its impact on human behaviour, and the interpretation and evaluation of thought, actions and behaviour. A culturally competent assessment therefore implies recognition of other issues sometimes associated with working with people from different cultures. These may include stigma, isolation, shame and embarrassment, and communication and language difficulties. Clinicians and other service providers such as interpreters and translators should be sensitive to these and other issues experienced by people from diverse cultural backgrounds in the detention setting. After-care and treatment planning also demands that practitioners understand the emphasis many cultures place on the involvement of family in the person's care and an understanding of the role of family and its implications, particularly in relation to confidentiality and gaining trust.

PAPUA NEW GUINEA REGIONAL RESETTLEMENT ARRANGEMENT CLIENT TRANSFER SUMMARY

Papua New Guinea (PNG) Regional Resettlement Arrangement (RRA) Transfer Operation: 7

Route:	Christmas Island > Darwin > Manus Island Regional Processing Centre
Date of departure:	Tuesday 13 August 2013
Date of arrival:	Wednesday 14 August 2013
Operation Leader:	Fiona Andrew, Assistant Secretary, National Operations and Capability Branch
Operation Contact No.	s. 22(1)(a)(ii) (Incident Command Centre Duty Officer)

Client Profile

The transfer group of 40 clients consists of the following:

- 40 single adult males

Comprising:

Number of clients	Nationality
38	Iranian
2	Iraq
TOTAL: 40	

Arrival Details

The clients arrived on the following vessels:

SIEV	Name	Prefix	Date of Interception	Date of Detention
807	Higdon	HGD	24 July 2013	25 July 2013
808	Kinston	KNS	24 July 2013	25 July 2013

Client Vulnerabilities

All clients being transferred as part of RRA transfer operation 7 have been assessed as fit to travel by the health service provider.

There will be two International Health and Medical Services escorts present on the flight to provide emergency medical assistance, if required.

Security Issues

None of the 40 single adult males identified for transfer from Christmas Island to Manus Island have been involved in any category of incident that would affect their security rating for aviation travel since arriving on Christmas Island.

To manage the increased operational risk associated with RRA Transfers, the Detention Service Provider will utilise an enhanced Emergency Response Team and Transport and Escort capability throughout the transfer operation.

Security arrangements

After taking into account available information concerning the transferring cohort, the following risk mitigation strategies are in place for this transfer:

- operations have been adjusted to take into account the risk profile of the transferring cohort;
- an enhanced detention service provided by the Emergency Response Team and Transport and Escort capability has been arranged; and
- an Emergency Command Centre has been established and will be operational throughout the transfer process both on Christmas Island and at the Serco office in Barton, ACT.

Escorts

Serco will be the lead escort agency for this transfer.

The following escorts will be present on the transfer:

Escort	Number of Escorts
DIAC	1
Serco	25
AFP	5
IHMS	2
Interpreters	2
	TOTAL: 36

PAPUA NEW GUINEA
REGIONAL RESETTLEMENT ARRANGEMENT
CLIENT TRANSFER SUMMARY

Pre-Transfer Activities (proposed)

Milestone	Local time	AEST
Transferees are moved from White 2 compound to support compound	0800	1100
Transferee processing commences	0830	1130
Pre-transfer processing is finalised	1725	2025
Transferees depart Christmas Island detention facility	1900	2200
Transferees arrive at airport	1920	2220
Aircraft departs Christmas Island	2000	2300

Flight schedule

Local	Route		Local Times		AEST	
Date	Origin	Destination	Departure	Arrival	Departure	Arrival
Tuesday, 13 August 2013	Christmas Island	Darwin	20:00 L	02:29 L (14/8)	23:00	02:59 (14/8)
Wednesday, 14 August 2013	Darwin	Manus Island	03:40 L	07:28 L	04:10	07:28

Transit arrangements

Christmas Island (clients embark) > Darwin (fuel only) > Manus Island (clients disembark)

During refuelling stops at Darwin en route to Manus Island, all clients and escorts will remain on the aircraft.

Reporting

Situation Reports (Sitreps) will be distributed by the departmental Incident Command Centre Duty Officer when the transfer has reached the following milestones:

- Transfer processes commence on Christmas Island
- Clients are informed that they are being transferred to Manus regional processing centre under the Regional Re-settlement Arrangement.
- Pre-transfer processing of clients is finalised.
- Clients depart Christmas Island Detention Centre for Christmas Island airport.
- Transfer Operation departs Christmas Island en route to Darwin.
- Transfer Operation arrives at Darwin to refuel.
- Transfer Operation departs Darwin en route to Manus Island.
- Transfer Operation arrives at Manus Island.
- Clients are processed and inducted into Manus Island regional processing centre.

PAPUA NEW GUINEA REGIONAL RESETTLEMENT ARRANGEMENT CLIENT TRANSFER SUMMARY

Primary contacts

Location	Name	Number	Role
National Office Incident Command Suite Duty Phone	s. 22(1)(a)(ii)	s. 22(1)(a)(ii)	Incident Command Centre Duty Officer
National Office Duty Phone	s 22(1)(a)(ii)		Duty Officer
National Office SES On-Call	Cath Wilson		SES On-Call
Christmas Island	Steven Karras		Regional Manager
Christmas Island	s. 22(1)(a)(ii)		Director, Detention Operations
Darwin	Scott Matheson		Regional Manager
Darwin	s. 22(1)(a)(ii)		Ag Director, Detention Operations
Canberra	Simon De Vere		Regional Manager PNG and Nauru
Manus Island	s. 22(1)(a)(ii)		Team Leader - Operations

Sitrep Distribution List

Organisation	Name	Position	Email
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	s. 22(1)(a)(ii)	Executive Officer (Secretary's Office)	
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	Wendy Southern	Deputy Secretary (Policy and Program Management Group)	
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	Elizabeth Cosson	Deputy Secretary (Business Services Group)	
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	Mark Cormack	Deputy Secretary (Immigration Status Resolution Group)	
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	Gavin McCairns	First Assistance Secretary, Risk, Fraud and Integrity	
	Stephen Allen	First Assistant Secretary, Border, Refugee and Onshore Services	
	s. 22(1)(a)(ii)	A/g Executive Officer, Immigration Status Resolution Group	
	Kerryn Vine-Camp	Assistant Secretary, Ministerial, Executive and External Acct	

PAPUA NEW GUINEA REGIONAL RESETTLEMENT ARRANGEMENT CLIENT TRANSFER SUMMARY

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	John Cahill	First Assistant Secretary, Detention Infrastructure and Services Division	
	Peter Speldewinde	A/g First Assistant Secretary, Status Resolution Services Division	
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	s. 22(1)(a)(ii)	National Communications Manager	
	s. 22(1)(a)(ii)	Media Director	
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	Luke Mansfield	Assistant Secretary, Program Analysis, Scrutiny and Evaluation Branch	
	Ross Hawkins	A/g Assistant Secretary, Support and Logistics Branch	
	Fatime Shyqyr	Assistant Secretary, Detention Infrastructure	
	Lynne Gillam	Assistant Secretary, Compliance Status Resolution	
	Simon Devere	Regional Processing Support Division	
	Simon Schiwy	Regional Processing Support Division	
	Cath Wilson	Assistant Secretary, BVE Program and Community Engagement	
	Neil Skill	Regional Processing Support Division	
	Brian Silkstone	Regional Processing Support Division	
	Scott Matheson	Regional Manager North	
	Steven Karras	A/g Regional Manager, Christmas Island	
	Janet Mackin	Regional Manager South	
	Steven Biddle	Regional Manager West	
	Steve Ingram	Regional Manager East	
	s. 22(1)(a)(ii)	Director, Strategic Planning and Logistical Support Section	
	s. 22(1)(a)(ii)	Director, Detention Operations, Christmas Island	
	Jasmine Newman	A/g Regional Manager Nauru and PNG/Assistant Secretary	
	s. 22(1)(a)(ii)	A/g Director, Client Transfers and Service Delivery	
	s. 22(1)(a)(ii)	Assistant Director, Intelligence,	

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	s. 22(1)(a)(ii)	Director, Quality Management Section	
	Mark Painting	Assistant Secretary, Services Management Branch	
	Paul Windsor	Assistant Secretary, Detention Health Services Branch	
	Cait Vignon	Director, Nauru Planning and Reporting	
	s. 22(1)(a)(ii)	Assistant Director, Nauru Planning and Reporting	
	s. 22(1)(a)(ii)	Director, Workforce Planning and Analysis	
	s. 22(1)(a)(ii)	Director, Service Delivery and Facilities, Christmas Island	
	s. 22(1)(a)(ii)	Director, Client Services, Christmas Island	
	s. 22(1)(a)(ii)	A/g Director, Case Management and Removals, Victoria	
	s. 22(1)(a)(ii)	Director, Detention Operations, Christmas Island	
	s. 22(1)(a)(ii)	Director, Detention Health Operations	
	Lisa Harris	Acting Assistant Secretary, Services Management Branch	
	s. 22(1)(a)(ii)	Director, Offshore Service Delivery Section	
	s. 22(1)(a)(ii)	Director, Intelligence, Risk and Planning Section	
	s. 22(1)(a)(ii)	A/g Director, Operational Support and Response Section	
	s. 22(1)(a)(ii)	Stakeholder Engagement and Capability Support Section	
	s. 22(1)(a)(ii)	Director, Manus Island RPC	
	s. 22(1)(a)(ii)	Manus Island RPC	
	s. 22(1)(a)(ii)	Manus Island RPC	
	s. 22(1)(a)(ii)	Director, Nauru RPC	
	Detention Operations Mailbox	National Operations and Capability Branch	s. 47E(d)
	National Communications Mailbox	National Communications Branch	
Minister's Office			s. 22(1)(a)(ii)
	Minister Burke		
	s 22(1)(a)(ii)	Minister's Office (Adviser)	
	s. 22(1)(a)(ii)	Minister's Office (Media Adviser)	
	s. 22(1)(a)(ii)	Minister's Office	
Serco			
	s. 22(1)(a)(ii)	Managing Director, Immigration	

PAPUA NEW GUINEA
REGIONAL RESETTLEMENT ARRANGEMENT
CLIENT TRANSFER SUMMARY

	s. 22(1)(a)(ii)	Director, Operations	s. 22(1)(a)(ii)
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)	Regional Manager	
Australian Federal Police			
	s. 22(1)(a)(ii)		
	Operation ETON		
	Operation ETON		
	Operation DUVAL		
Defence			
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		
Prime Minister and Cabinet			
	s. 22(1)(a)(ii)	Associate Secretary (National Security Adviser)	
	s. 22(1)(a)(ii)	Deputy National Security Adviser	
Attorney General's			
	Crisis Coordination Centre		
Department of Foreign Affairs and Trade			
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		
	s. 22(1)(a)(ii)		

PRE-TRANSFER ASSESSMENT FORM

(Version 0.2 in use from 29 July 2013 for persons who arrived after the 19 July 2013 announcement)

All unauthorised maritime arrivals who enter Australia on or after 13 August 2012 are liable to have their protection claims assessed in a designated regional processing country (RPC).

In addition, on 19 July 2013, the Government announced that unauthorised maritime arrivals from the time of the announcement will be subject to transfer to Papua New Guinea for assessment of any protection claims and if found to be refugees will be settled there.

A Pre-Transfer Assessment is to be undertaken by case managers to determine whether:
(a) The person falls within any of the classes of persons in relation to which the Minister has exercised his power under s198AE, such that he has determined that s198AD does not apply;
(b) The case is one that the Minister has indicated in his section 198AE guidelines should be referred to him to consider whether he will exercise his section 198AE power;
(c) There are specific client circumstances or special needs that mean it is not reasonably practicable to transfer the client to a RPC at this time.

Case managers should make a recommendation to the senior case manager as to the readiness of a person to be transferred to a RPC based on the advice of key internal stakeholders (as outlined below).
This form is to be completed having regard to the guidance provided in the Departmental guidelines under s198AD(2) of the Migration Act 1958 (the Act) to determine when it is reasonably practicable to take a person to an RPC, and bearing in mind the Guidelines for referral of cases to the Minister for him to consider the Exercise of Ministerial discretion under s198AE of the Migration Act 1958 (the Act) (s198AE Guidelines).

An adult family member or independent observer must be present in any interview between a DIAC officer and a minor (including a person who claims to be a minor).

Client Biodata

Client Name:
Boat ID:
Date of birth:
Citizenship:
Ethnicity:
Language:
Gender:

Section 1 – Persons exempt from transfer to a regional processing country

This section should be completed with reference to any determination made by the Minister for Immigration, Mulitcultural Affairs and Citizenship under s198AE of the Act. Relevant determinations are published on LEGEND at 'OTHER INSTRUMENTS – registered and non-registered' and individual exemptions recorded in departmental systems.

Assessment:

□ The person does not fall within a class of unauthorised maritime arrivals in respect of whom the Minister has made a determination under s198AE of the Act. ***(Continue with Section 2).***

□ The person falls within a class of persons in respect of whom the Minister has made a determination under s198AE of the Act/ or the Minister has previously decided to exempt the person from being taken by use of his s198AE power. ***(If yes, provide details in the comments below, and proceed to Section 8A and finalise the PTA indicating that a Ministerial Determination has been made that applies to the person).***

Comments:

_____

_____

Section 2 – Reasonably Practicable - health and other special needs

Officers should ensure that at the time of completing the PTA a fitness to transfer assessment has been carried out by the Detention Health Services Provider. The pre-transfer assessment must be delayed until the health assessment is completed.

Any questions are to be referred to the Health Services Provider Regional Medical Director, with copies to the Director, Detention Health Operations and the Detention Health mailbox
s. 47E(d)

Assessment:

□ The Detention Health Services Provider has assessed the person as fit to transfer and the person has no apparent special needs or the special needs identified can be managed in the RPC.

□ The Detention Health Services Provider has assessed the person as not fit to transfer or other special needs have been identified (in accordance with the s198AD(2) Guidelines) and require further assessment.

Comments:

_____

_____

_____

Section 3 – Reasonably Practicable - logistical issues

There may be logistical reasons that make it not reasonably practicable to take a person to a RPC. For example there may be no capacity for the person to be accommodated in the RPC.

Assessment:

□ There are no capacity or other logistical reasons indicating it is not reasonably practicable to take the person to a RPC.

□ There is outstanding litigation, a court order or other ongoing legal matter relating to the person.

[As a matter of policy any person liable for transfer who has outstanding litigation, a court order or other ongoing legal matter currently under consideration will not be transferred. Officers must check departmental systems or contact s. 47E(d) *to establish whether any legal matters are ongoing.]*

□ A Criminal Justice Stay Certificate is in force requiring that the person not be removed from Australia at this time.

[Officers should also check departmental systems for evidence of a Criminal Justice Stay Certificate (CJSC) issued to stay the person's removal from Australia. Further checks must be undertaken by emailing Character Operations Section in National Office (email a bulk request to s. 47E(d)

□ There are capacity or other logistical reasons indicating it is not reasonably practicable to take the person to a RPC at this time but it will be possible in the foreseeable future.

Comments:

_____

_____

_____

_____

Section 4 – Minors

Any person who credibly claims to be a minor must have a separate Best Interests Assessment (BIA) as part of the PTA. A transfer to a RPC for a minor cannot proceed until the BIA has been endorsed. Guardianship Policy Section in national office s. 47E(d) *should be notified of PTAs being prepared in respect of a minor (whether unaccompanied or as part of a family unit).*

Assessment:

The person credibly claims to be a minor and the BIA has identified that:

□ There are no exceptional circumstances indicating the minor should not be transferred to the RPC at this time.

□ The minor should not be transferred at this time due to reasons outlined in the BIA.

Comments:

_____

_____

_____

Section 5 – Opportunity to comment where transfer appears to be reasonably practicable

Officers must ask the below questions of all clients where it appears the transfer is reasonably practicable (ie no issues or barriers identified). If new information is provided which has not previously been provided, the relevant section of the PTA Form will need to be reassessed.

The below text is to be read to the client:

Based on the information available to the department, you have been assessed as suitable to be taken to Papua New Guinea [or refer to another relevant RPC]. You now have an opportunity to comment on this assessment. The information you provide to us will be considered against the other information available to the department before the final decision is made on whether you will be transferred.

5A. Do you have any health issues that you have not told us about?

Client response:

_____

_____

_____

5B. Do you have any other special needs that you feel should be taken into account?

Client response:

_____

_____

_____

5C. Is there any reason you fear being transferred? *(Refer to each designated RPC.)*

Client response:

_____

_____

_____

Australia has an obligation under international law not to send a person to a place where there is a real risk that they would be arbitrarily killed; have the death penalty carried out on him/her; be subjected to torture, or cruel, inhuman or degrading treatment or punishment; or where they have a well-founded fear of being persecuted on account of his/her race, religion, nationality, membership of a particular social group or political opinion.

Where claims against a RPC have been raised, the officer should refer to the relevant country information sheet, which includes the assurances given by the RPC (see TRIM Link: ADD2013/59928), to determine if the claims are credible.

Advice on protection claims can be sought from an Onshore Protection officer with training and expertise in the consideration of protection claims by contacting the Director, IMA and RSA Support, Western Australia on s. 47E(d) *or* s. 47E(d) *for urgent matters.*
If the person makes credible protection claims against all designated RPCs, officer should consider whether the person meets the section 198AE guidelines and refer if appropriate.

Officers must not consider any protection claims put forward by the person against their home country. Protection claims against the unauthorised maritime arrival's home country will be assessed by the RPC.

Section 6 - Protection claims made against a regional processing country

Assessment:

□ The person has not made any protection claims against the regional processing country or countries.

□ The person has made protection claims against the regional processing country/countries and, with reference to the available country information and the assurances given by the RPC and in consultation with Onshore Protection (as required):

- □ the claims are not considered to be credible.
- □ the claims are credible in relation to one of the RPCs <state RPC name> but not in relation to <state other RPC> and therefore the person can be transferred to the RPC <state RPC name>.
- □ the claims are credible in relation to all designated RPCs and should be referred to the Minister for consideration of the exercise of his power under section 198AE.

Comments:

_____

_____

_____

Section 7 – Assessment by Officer

Having regard to the information provided by the person; the advice of relevant key internal stakeholders; and responses to the questions at Section 7 (if relevant), I find that:

□ **7A. It is reasonably practicable to take the person to a RPC, there are no barriers to the transfer and arrangements for transfer can therefore proceed.**

7B.Transfer cannot proceed due to existence of s198AE Ministerial exemption (select one)

□ The person falls within a class of unauthorised maritime arrivals in respect of whom the Minister has made a determination under s198AE of the Act to determine that s198AD does not apply.

OR

□ The Minister has determined under s198AE that s198AD does not apply to the person.

7C. It <u>may be</u> reasonably practicable to take the person in foreseeable future, the transfer of the person to a RPC <u>cannot be progressed</u> at this time (select all that apply)

□ The Detention Health Services Provider has assessed that the person is not fit to transfer or has other special needs which cannot be managed satisfactorily in a RPC at this time. ***(The case must continue to be managed to resolution in consultation with the Detention Health Services Provider)***

□ There is outstanding litigation, a court order or other ongoing legal matter relating to the person.

□ A Criminal Justice Stay Certificate is in force requiring that the person not be removed from Australia.

□ There are capacity or logistical reasons indicating it is not reasonably practicable to take the person to a RPC at this time (but it will be possible in the foreseeable future).

□ The person credibly claims to be a minor and the best interests assessment has identified that the minor should <u>not</u> be transferred at this time (but may be possible in the future).

□ Other:_____

□ **7D. The person has made credible protection claims against all designated RPCs and the case should be referred to the Minister consistent with his s198AE guidelines. Transfer cannot proceed at this time.**

_____

Name:
Case Manager
Position Number:

Date:

Section 9 – Assessment by Supervisor

In relation to s. 47F(1) and having particular regard, where applicable, for the responses provided by the client at Section 7:

□ I agree with the assessment made by the officer at Section 8.

□ I do not agree with the assessment made by the officer at Section 8 and make the following alternative assessment: (If you are disagreeing with an officer's finding at section 1, that the person falls within a class of persons in respect of whom the Minister has made a determination under s198AE of the Act/ or the Minister has previously decided to exempt from being taken by use of his s198AE power you must direct the officer to complete sections 2-7 before making your final decision.)

_____

_____

_____

In accordance with the current ministerial direction under s 198AD(5) of the *Migration Act 1958* available on LEGEND, the person should be taken to:

□ Papua New Guinea;

□ Nauru;

□ Not relevant (transfer not reasonably practicable at this time).

This assessment remains valid for a period of seven days from the date of signature.

Comments:

_____

_____

_____

_____

Name:
Assistant Director Case Management
Christmas Island
Position Number:
Date:

Detention Services Manual
Chapter 6 - Detention health
Food/fluid refusal

About this instruction

This departmental instruction comprises:

- Introduction
- Food/fluid refusal
- Management
- Group food/fluid refusal
- Determining mental competence
- Medical support and intervention
- Ceasing food/fluid refusal
- Staff considerations
- Timeframes
- Secretary's proforma.

Related instructions

- DSM - Chapter 1 - Legislative and principles overview - Service delivery values
- DSM - Chapter 1 – Legislative and principles overview - Duty of care to detainees
- DSM - Chapter 1 – Legislative and principles overview - Guardianship
- DSM - Chapter 6 – Mental health screening
- DSM - Chapter 6 – Psychological support program.

Latest changes

Legislative

Nil.

Policy

This instruction, which is part of the centralised Departmental instructions system (CDIS), was reissued on 23 November 2013.

Owner

Stakeholder and Health Strategy Section
Detention Health Services Branch
Detention Infrastructure and Services Division
National Office

Email

s. 47E(d)

Contents summary

Introduction

1 Purpose

The purpose of this instruction is to provide policy advice to departmental officers and service providers dealing with persons in immigration detention facilities (detainees) who engage in food and/or fluid refusal.

The term "food/fluid refusal" will be used in this instruction to refer to both food and/or fluid refusal. However, it should be noted that there are significant differences in the timing and severity of health impact between food and fluid refusal and refusal only of food.

2 General principles

Refusing food and/or fluids can be seen as a form of non-violent protest activity, generally used to bring attention to a complaint, influence an outcome or effect change.

Complete refusal of fluids is particularly dangerous to a person's health. If all food and fluids are refused, the detainee must be monitored very closely (at least 12 hourly) by the health services manager (HSM) for potential transfer to hospital (see section 4 Definitions).

The health care and management of detainees is a shared responsibility between the department, the detention service provider (DSP) and the HSM.

For the purpose of this instruction it is assumed that some amount of fluid is being consumed by a detainee undertaking food/fluid refusal. For instances where both food and fluid are being refused, refer to section 6 Refusal of both food and fluids.

The general principles for food/fluid refusal in immigration detention are that:

- all communication with a detainee who is engaging in food/fluid refusal must occur in a language they can easily understand
- all instances of food/fluid refusal will be appropriately documented, reported, escalated and monitored
- detainees will have access to qualified health care providers for the treatment and management of identified health concerns or issues
- the HSM makes clinical decisions about a detainee's health status and informs stakeholders where relevant to the detainee's care while in immigration detention, and
- engaging in food/fluid refusal will not affect immigration outcomes.

Departmental policy is that:

- engaging in food/fluid refusal will not influence decision making
- detainees will not be force fed (except as per regulation 5.35 - see section 20 Secretary's authorisation)
- detainees will have access to appetising and culturally appropriate food and water at all times
- decisions will be informed medical assessment

- detainees will be actively managed by all service providers and the department and
- records will be kept.

3 Overview

Detainees who engage in food/fluid refusal must:

- have access to food, water and medical services at all times
- have regular medical assessments, at least 24 hourly, except when refusing both food and fluid, then medical assessments will be at least 12 hourly
- be encouraged by staff to find a different way to express their concerns and cease their food/fluid refusal. However, the person must not be forced to eat or drink and
- be provided with supervision by staff in as non-intrusive a manner as possible.

4 Definitions

Case manager

A departmental officer who ensures that work on each case is being undertaken by all relevant parties in a coordinated, logical and planned way, to ensure timely progress towards resolution of immigration status for detainees including those with complex, sensitive or exceptional circumstances.

Delegated guardian

A person to whom the Minister has delegated duties and functions as legal guardian of an unaccompanied minor, under the *Immigration Guardian of Children (IGOC) Act (1946).*

Detention services provider (DSP)

An organisation contracted by the department to manage all operational and general welfare aspects of immigration detention facilities.

Heath care provider (HCP)

A health care professional, such as a general practitioner (GP), registered nurse, or allied health professional engaged by the health services manager to provide health care to detainees.

Health care record

The health services manager creates a health care record for detainees at the time of the health induction assessment. The record is managed in accordance with privacy and confidentiality requirements, and in line with their professional registration and codes of conduct. The record contains confirmation of consent (or refusal) and a note of all relevant details (including any follow-up action or referrals) relating to the outcome of any treatment.

Health induction assessment (HIA)

The assessment of a person in immigration detention/regional processing centre to determine their health status shortly after entering immigration detention/ regional processing centre.

Health services manager (HSM)

Health services organisation contracted by the department to facilitate access to health care for detainees.

Unaccompanied minor (UAM)

An unlawful non-citizen under the age of 18 for whom the Minister is the guardian under the IGOC Act.

Under the IGOC Act, a person is generally an unaccompanied minor where they:

- are under 18 years old and
- at the time of their arrival in Australia intended to become a permanent resident of Australia and
- at the time of their arrival in Australia did not enter Australia in the charge of, or for the purposes of living in Australia under the care of, a parent, a relative who has turned 21, or an intending adoptive parent.

Food/fluid refusal

5 What is food/fluid refusal

For the purposes of this instruction, food/fluid refusal is defined as the decision of a mentally competent person to voluntarily refuse to take food and/or fluids for a significant interval.

Although food/fluid refusal is generally a voluntary act by a mentally competent and rational person, it is important to note that, in some cases, people may have been coerced or forced to undertake food/fluid refusal, possibly as part of a mass protest. Most incidents of food/fluid refusal will end because of a voluntary decision by that person to resume eating.

For the purpose of this instruction, a detainee is considered to be undertaking food/fluid refusal if:

- they give formal advice that they are engaging in food/fluid refusal
- there is advice from others that a detainee is engaging in food/fluid refusal
- staff observe that the detainee may be, or is, undertaking food/fluid refusal
- they have not consumed any food in a 24 hour period and they confirm or do not deny that they are pursuing food/fluid refusal.

If food/fluid refusal is claimed or suspected, the detainee *must* be immediately referred to the HSM for a clinical assessment by the person suspecting the case of food/fluid refusal.

6 Refusal of both food and fluids

The refusal of both food and fluids can very quickly produce serious and sometimes irreversible health problems and lead to death within a relatively short time. Immediate action is necessary by staff involved in the detainee's care as a lack of fluid can cause problems with kidney function within a few days.

Through education and consultation, the person may agree to limit their refusal to solid foods only and agree to consume fluids.

It must be considered that by the time food/fluid refusal is determined, the individual has already potentially been without fluids for 24 hours.

The HSM must closely monitor the detainee and advise Immigraiton if transfer to a hospital is necessary. In extreme cases, the Secretary may decide to intervene in the case if the detainee continues to refuse both food and fluids. See section 20 Secretary's authorisation.

7 Reporting

7.1 Roles

The DSP, HSM and the department are responsible for the reporting of food/fluid refusal cases. The DSP and HSM must file an incident report with the department as per their procedures and contractual obligations.

The HSM must notify the department (in writing) of the following *critical* events:

- within 24 hours of confirming the episode of food/fluid refusal if the detainee is refusing both food and fluids and
- within 72 hours of confirming the episode of food/fluid refusal if the detainee is refusing food only.

A detainee must be assessed by the HSM as soon as possible, but at least within 48 hours of commencing food/fluid refusal (that is, they must see the detainee within 24 hours of notification by the DSP of the food/fluid refusal). If however, the detainee is engaging in BOTH food and fluid refusal the HSM must see the detainee immediately.

Following the notification to the department by the HSM, the HSM must provide the department with updates at least every 24 hours.

The DSP must notify the department:

- in any case where food/fluid refusal is claimed or suspected, and the detainee has not consumed any food within 24 hours.

Following the notification to the department by the DSP, the incident report should be updated at least every 24 hours until the detainee confirms the cessation of the protest or the detainee is observed eating. See section 22 Staff support.

7.2 Departmental staff

Minimising the risk of injury for all detainees is the critical aim before, during and after incidents of food/fluid refusal.

When food/fluid refusal is first reported, the exact reason/s that the detainee gives for refusing to consume food/fluids must be recorded in relevant systems. This information can assist in determining whether or not the incident is classified as food/fluid refusal or if other health intervention is required. The information is also important to aid in identifying motivation and developing an effective intervention strategy.

A food/fluid refusal incident may be high profile and can attract the attention and interest of departmental senior management, the Minister, external scrutiny bodies, advocates and the media. These stakeholders will be interested in all aspects of the food/fluid refusal, in particular ensuring that the department is taking active steps to manage the situation and the health of detainee engaging in food/fluid refusal. Most of all, they will want to know that the department is implementing an intervention strategy. High profile cases should be reported according to agreed processes, for example, situation reports (sitreps).

Detainees must be made aware that food/fluid refusal will not enable them to receive special, preferential or priority treatment, and will not influence any decisions made regarding their immigration status. See DSM – Chapter 8 - Safety and security - Incident management and reporting for more information.

8 Access to services

A detainee must be assessed by the HSM as soon as possible, but at least within 48 hours of commencing food/fluid refusal (that is, they must see the detainee within 24 hours of notification by the DSP of the food/fluid refusal).

If however, the detainee is engaging in BOTH food and fluid refusal the HSM must see the individual immediately. If the HSM is not available (such as due to weekends/public holidays) the DSP should escalate as per local procedure (transfer to hospital etc) to ensure timely clinical review. Unless the detainee engaging in food/fluid refusal is a child, in which case they should be transferred to hospital immediately - see section 15.3 Determining the capacity of a minor to decide consent.

It must be considered that by the time an episode of food/fluid refusal is reported, the detainee has not consumed food and/or fluids for 24 hours.

If the episode is one of both food AND fluid refusal, the HSM must assess the detainee immediately.

9 Why persons may engage in food/fluid refusal

The motivation of a detainee undertaking food/fluid refusal must be understood in order to effectively manage their behaviour.

Detainees may undertake food/fluid refusal for a range of reasons including:

(a) to influence an immigration outcome, that is, they believe the political pressure of their actions may result in a positive outcome or a change in their conditions (including preventing removal or transfer)

(b) to raise a complaint or in reaction to a negative outcome

(c) for broader political reasons

(d) self-harm: however, it should be noted that food/fluid refusal will not be managed under the psychological support program (PSP) policy unless clinical assessments indicate that a PSP intervention is appropriate

(d) dieting, religious fasting etc.

(e) mental health issues

(f) illness - particularly if the reason for not eating is that they feel too sick to eat, or are trying to eat but have no appetite and

(g) stress.

All cases of food fluid refusal must be referred for assessment to the HSM as soon as possible. Only points a, b, c and in some cases d, are food/fluid refusal instances intended to be covered by this policy. Other instances of refusing food or fluids require a different management approach by the HSM in line with best clinical practice.

Management

10 Developing an intervention strategy

An intervention strategy must be developed to manage a food/fluid refusal incident. The aim of the intervention strategy is to encourage the detainee to cease food/fluid refusal. All actions undertaken by Immigraiton staff and service providers must be directed towards achieving this aim. The intervention strategy should be comprehensive and involve a coordinated, considered approach by all stakeholders.

Food/fluid refusal management involves removing motivation and any potential influencing factors (such as removing ringleaders in instances of group food/fluid refusal) while providing continuous access to appetising food and fluid.

Experience has shown that the best results are achieved by the early and consistent coordination of information regarding the situation, observations and review by the HSM as well as intervention by mediators.

The strategy must:

- involve communication and negotiation in the first instance
- be appropriate to each circumstance
- never be disciplinary
- seek to maintain good relationships
- consider the safety and well-being of all persons concerned when responding to health related behavioural incidents.

11 Appropriate courses of action

Intervention strategies must be developed and managed on a case-by-case basis. Each intervention strategy will differ according to the circumstances of each individual detainee involved, and the circumstances of the individual incident.

11.1 Engagement - identifying and removing motivation

The most effective means to encourage a detainee to cease food/fluid refusal is to identify and remove their motivation for continuing food/fluid refusal. This may be by engaging directly with the detainee, recognising that complex behaviour management may be required. However, no concessions in relation to immigration outcome will be made.

11.2 Communication

Effective engagement and communication with detainees engaging in food/fluid refusal is critical to assessing and removing the motivators driving their action.

The key is open communication and ensuring a consistent and sensitive approach to managing a food/fluid refusal incident. This includes:

- interpreters, who have been briefed on the situation
- minimum number of staff communicating with the detainee to ensure consistent messages and
- active facilitation of communication between the department, HSM and DSP.

The department does not negotiate an immigration outcome with detainees engaging in food/fluid refusal.

It is acknowledged that good faith demonstrations may be appropriate in some instances (this could include, for example, specific foods etc.). However, concessions should not be promised or given to any detainee engaging in food/fluid refusal (such as, for example, expedited visa processing etc.).

11.3 Access to food

In some cases, a detainee may continue eating, possibly in secret, while maintaining that they are still undertaking food/fluid refusal.

Continuous food, appropriate to the needs of the detainee (culturally appropriate) and water must be available as it can be an effective means of undermining the motivation to continue with food/fluid refusal.

DSP staff should discretely note what food/fluid has been consumed. Detainees may be less likely to eat if they believe that their consumption is being closely watched.

There is a risk that increased access to food may be perceived as rewarding a detainee who engages in food/fluid refusal. However, this does not outweigh the health considerations.

12 Food/fluid refusal and removal/transfer from Australia

Food/fluid refusal may in some instances be undertaken as a means of stopping removal or transfer. Engaging in food/fluid refusal is not a barrier to removal.

If a food/fluid refusal incident is likely to impact on a planned removal or transfer, the case manager should notify the local removals officer and Returns and Removals Strategy and Support Section, National Office as soon as possible (s. 47E(d)

See PAM3: Act – Compliance and Case Resolution – Case resolution – Removal from Australia for more information.

Group food/fluid refusal

13 Management and accommodation

The World Medical Association recommends that groups engaging in food/fluid refusal be separated into small groups or even individuals to remove motivation. While this may be difficult to facilitate, separation and isolation from other individuals engaging in food/fluid refusal is very effective at removing motivation.

It is recommended that detainees be accommodated in locations that facilitate appropriate observations and/or monitoring and engagement by the HSM and the DSP.

Determining mental competence

14 Overview

Psychological consultations are necessary to establish and monitor the mental competence of a detainee undertaking food/fluid refusal.

The HSM (or HCP) is responsible for determining a detainee's mental competence. A detainee who is not mentally competent cannot be considered to be undertaking food/fluid refusal.

Whether a minor is able to be deemed competent is at the discretion of the HCP as per guidance below.

15 Consent and unaccompanied minors

15.1 Child protection obligations

If a minor engages in food/fluid refusal it is essential to determine if they are engaging in food/fluid refusal on their own accord, or if they have been forced or coerced by their parent/s or legal guardian, or are being unduly influenced.

Article 19 of the Convention on the Rights of the Child, to which Australia is a signatory states:

> *States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child …*

Forcing, coercing or unduly influencing a minor to engage in food/fluid refusal is a form of abuse.

If a minor has been forced or coerced to engage in food/fluid refusal, it must be reported both through the appropriate departmental reporting system as per section 7 Reporting and appropriate action must be taken in consultation with relevant State/Territories authorities in the best interests of the child. Any action must be in accordance with child protection obligations. In most cases, where there is concern for the child's wellbeing the child should be transferred to hospital immediately. The obligation to report to State/Territory authorities lies with the department, the HSM and the DSP.

15.2 Unaccompanied minors

This advice also applies to unaccompanied minors for whom the Minister is the guardian.

The Minister is the guardian where a non-citizen who is under 18 and on arrival in Australia made claims for protection, and was not accompanied by a parent or relative over the age of 21. If there is doubt as to whether the Minister is the guardian for a minor the Guardianship Policy Section, National Office can provide advice on the status of the minor (email

s. 47E(d)

15.3 Determining the capacity of a minor to decide consent

Minors, including unaccompanied minors, are capable of giving informed consent when they achieve a sufficient mental capacity and intelligence to understand the implications of their actions.

Unless there is information or evidence to the contrary, an unaccompanied minor who is 16 or 17 should generally be treated as having capacity to consent to medical treatment, and as such to make the decision to engage in (and cease) food/fluid refusal. As such they should be engaged with as though they are an adult.

Similarly, unless there is information stating otherwise, an unaccompanied minor who is under 16 should generally be treated as not having the capacity to consent. Either way, a determination should be made by the HSM.

15.4 If an unaccompanied minor does not have the capacity to decide consent

If the unaccompanied minor is clinically assessed as not being capable of giving informed consent to medical treatment, the delegated guardian can provide consent for medical treatment. As such, the minor also cannot be deemed as having the capacity to engage in food/fluid refusal. Appropriate records must be kept that outline reasons for decisions made. Reporting to State/Territory authorities must be made as required. If the minor is engaging in food/fluid refusal an appropriate management plan must be developed that takes into consideration the minor's lack of mental capacity.

15.5 If an unaccompanied minor has the capacity to decide consent

If an unaccompanied minor declines to give consent to a clinically indicated procedure the delegated guardian cannot provide consent on their behalf if the minor has been clinically assessed as capable of giving consent and therefore has capacity to engage in food/fluid refusal. In these circumstances, the unaccompanied minor should be treated in accordance with the procedures for an adult who is refusing to provide consent. Appropriate records must be kept and reporting to State/Territory authorities must be made as required.

Medical support and intervention

16 Overview

Medical support, that is, daily contact and assessment by the HSM during the episode of food/fluid refusal, must be provided to the detainee. Medical intervention, that is, intervening as clinically indicated, may become appropriate in certain circumstances. A person's physical and mental health is the main priority in cases of food/fluid refusal.

17 About medical support and intervention

The most important consideration in managing a detainee undertaking food/fluid refusal is the person's physical and mental health.

18 Medical intervention

In the later stages of food/fluid refusal, serious medical intervention may become necessary as the detainee's health deteriorates.

The World Medical Association has established guidelines for doctors involved in managing persons on food/fluid refusal. The Declaration of Tokyo (1975) and the Declaration of Malta both prohibit the use of non-consensual force-feeding of a person undertaking food/fluid refusal while that person is mentally competent. However the ultimate decision on intervention or non-intervention is reserved for the treating doctor acting in the best interests of the person.

Any instances where the detainee has lost consciousness (irrespective of the perceived cause of the loss of consciousness) should result in the detainee being transferred to hospital immediately.

19 Transfers to hospital

The transfer to hospital of a detainee undertaking food/fluid refusal is to be conducted in accordance with standard procedures for all hospital transfers.

20 Secretary's authorisation

Regulation 5.35 provides the Secretary with authority to order the initiation of medical treatment, specifically, the administration of nourishment and fluids and treatment in a hospital for a detainee, without the detainee's consent. See Secretary's proforma.

Note: Regulation 5.35 applies only to persons in immigration detention centres and not to persons in immigration residential housing, immigration transit accommodation, alternative places of detention or community detention.

The Secretary cannot act before receiving written advice on the issue from a Commonwealth Medical Officer or a registered medical practitioner. Once regulation 5.35 has been invoked, a medical practitioner must be engaged to commence treatment.

It is departmental policy that this authorisation is only invoked if:

- the detainee fails to give, refuses to give, or is not reasonably capable of giving, consent to medical treatment and
- when there will be a serious risk to the detainee's life or health.

Ceasing food/fluid refusal

21 The decision to cease food/fluid refusal

The decision to cease food/fluid refusal must be made by the detainee undertaking the food/fluid refusal.

For the purposes of this policy, a person is considered to have ceased food/fluid refusal when the DSP observes the detainee consuming any two meals in a 24 hour period.

A detainee ceasing food/fluid refusal must be offered a medical assessment and receive psychological counselling. Note: The re-introduction of food may need to be managed by the HSM.

The DSP should provide ongoing support to the detainee with view to preventing another episode of food/fluid refusal.

Staff considerations

22 Staff support

Managing an episode of sustained food/fluid refusal can be very draining on staff, both physically and emotionally. All departmental staff involved in the management of food/fluid refusal incidents should routinely have access to the Employee Assistance Program (EAP) for counselling and debriefing services during, and after, an incident of food/fluid refusal.

The DSP, HSM, interpreters and other involved parties should also encourage their staff to access their contracted counselling support.

Timeframes

23 Timeframes around risks to health

The medical complications and risks associated with food/fluid refusal increase as food/fluid refusal continues. This has implications for the intervention strategy.

The following timeframes are a guide on the risk to health with food/fluid refusal but will vary from person to person – the following timeframes are only a guide. The refusal of both food and fluids carries a significantly higher health risk and should be monitored carefully by the HSM. Serious health impacts can occur after only a few days of total fluid refusal.

Days 1-10

Food/fluid refusal is hard and painful as most people are unable to withstand the drive to eat.

Medical advice indicates that the first four to seven days of a food/fluid refusal are particularly difficult, but after this period the body adjusts to a reduced diet and the feeling of hunger is controlled.

This means that early intervention within the first seven days of a food/fluid refusal incident is likely to be the most successful. Every effort should be made to encourage the detainee to recommence eating in the first week. Small efforts at this stage will be more effective than larger efforts later when the detainee is established in their course of action and may no longer feel the adverse effects of hunger.

For this reason, passive approaches to the intervention strategy are highly risky. For example, choosing not to engage with a detainee may be an appropriate strategy in some circumstances, but can squander the benefits of early intervention and entrench the food/fluid refusal incident if not successful.

Days 10-50

From day 10 of food/fluid refusal, physical symptoms, such as the loss of fat and muscle mass become more acute and mental competence diminishes. The change in electrolyte balance in the body affects the hunger drive and much of the pain of hunger is replaced by lethargy and a low-intensity constant headache. This is considered to be starvation.

Characteristic symptoms of starvation include:

- shrinkage of vital organs (such as the heart, lungs, ovaries, or testes) and gradual loss of their functions
- chronic diarrhoea
- headache
- anaemia
- reduction in muscle mass and consequent weakness
- lowered body temperature combined with extreme sensitivity to cold

- decreased ability to digest food because of lack of digestive acid production*
- irritability and difficulty with mental concentration
- immune deficiency
- swelling from fluid under the skin and
- decreased sex drive.

*Note: this impacts on the food that should be made available as it must be easy to digest (such as broth).

These physiological effects may affect the engagement with the detainee and will impact on their motivation to disengage from the food/fluid refusal process. During this period, the usual hunger drive is dulled and the person undertaking food/fluid refusal may experience a dream-like or meditative state.

The mental competence of the person to make rational decisions about refusing or accepting food and/or fluids becomes an issue, and the HSM should closely monitor the person in this phase as a guardian may need to be appointed to protect the interests of the person engaging in food/fluid refusal.

As each day passes, it becomes harder for the detainee to recommence eating spontaneously. Food becomes difficult to chew and swallow, and even small amounts can induce stomach cramps and nausea. By this stage, re-feeding should only commence under medical supervision.

Around 20-30 days potentially irreparable organ and brain damage may occur.

Day 50 and beyond

This is the most serious phase of a food/fluid refusal incident, and requires the most radical intervention to protect the health and safety of a detainee undertaking food/fluid refusal.

Complete starvation in adults leads to death within 8 to 12 weeks (56-84 days). In the final stages of starvation, adults experience a variety of neurological and psychiatric symptoms, including hallucinations and convulsions, as well as severe muscle pain and disturbances in heart rhythm.

From around day 50 of a food/fluid refusal incident, the focus must be on medical support and intervention to end the incident safely. Obviously, with any incident of food/fluid refusal there must be a strong focus by all involved parties to end the incident as soon as possible.

Secretary's proforma

APPLICATION TO THE SECRETARY

FOR AUTHORITY FOR MEDICAL TREATMENT

(Regulation 5.35 of the Migration Regulations 1994)

I, being the undersigned registered Medical Practitioner responsible for the *provision of* medical care for the following detainee being held at _____ Centre under the Migration Act 1958.

Name of detainee: _____

ID number: _____ Date of Birth _____/_____/_____

I am of the opinion that (insert name)_____

is in need of medical attention and if the following medical treatment is not given there will be a serious risk to his/her life or health:

(insert details of medical condition and treatment required)

_____
_____
_____
_____ (if insufficient space please refer to attachment Yes/No)

He/she:

1. Has failed to give consent to the required medical treatment.

2. Has refused to give consent to the required medical treatment.

3. Is not reasonably capable of giving consent to the required medical treatment.

Delete as applicable.

Therefore, I am requesting an authorisation by the Secretary to the Department of Immigration and Border Protection under Regulation 5.35 of the Migration Regulations whereby medical treatment as stated above may be given to the above named detainee without his/her expressed consent.

_____

Signature

_____ Dated this _____

Print Name

AUTHORITY OF MEDICAL TREATMENT TO BE GIVEN UNDER REGULATION

5.35 OF THE MIGRATION REGULATIONS

I, Martin Gerard Bowles, Secretary to the Department of Immigration and Border Protection, acting under subregulation 5.35(2) of the Migration Regulations and on the written advice of

Dr _____ (who is a registered medical practitioner) have formed the opinion that

_____ ("the detainee"), being a person held at a detention centre in detention under the *Migration Act 1958*, needs medical treatment, and that if medical treatment is not given to the detainee there will be a serious risk to his or her life or health; and further that the detainee fails to give, refuses to give, or is not reasonably capable of giving consent to medical treatment.

Accordingly, I hereby authorise medical treatment requested above, within the meaning of regulation 5.35 of the Migration Regulations, to be given to the detainee.

_____ Dated this _____

(Martin Bowles)

Regulation 5.35

5.35 Medical treatment of persons in detention under the Act

5.35 (1) In this regulation:

detainee

means a person held at a detention centre in detention under the Act;

medical treatment

includes:

(a) the administration of nourishment and fluids; and

(b) treatment in a hospital.

(2) The Secretary may authorise medical treatment to be given to a detainee if:

(a) the Secretary, acting in person and on the written advice of:

(i) a Commonwealth Medical Officer; or

(ii) another registered medical practitioner;

forms the opinion that:

(iii) that detainee needs medical treatment; and

(iv) if medical treatment is not given to that detainee, there will be a serious risk to his or her life or health; and

(b) that detainee fails to give, refuses to give, or is not reasonably capable of giving, consent to the medical treatment.

(3) An authorisation by the Secretary under subregulation (2) is authority for the use of reasonable force (including the reasonable use of restraint and sedatives) for the purpose of giving medical treatment to a detainee.

(4) A detainee to whom medical treatment is given under an authorisation under subregulation (2) is taken for all purposes to have consented to the treatment.

(5) Medical treatment that is given under an authorisation under subregulation (2) must be given by, or in the presence of, a registered medical practitioner.

(6) Nothing in this regulation authorises the Secretary to require a registered medical practitioner to act in a way contrary to the ethical, moral or religious convictions of that medical practitioner.

Detention Services Manual
Chapter 6 - Detention health
General health screening and management

About this instruction

This departmental instruction comprises:

- Introduction
- Overview
- General health assessment
- Tuberculosis screening and management in immigration detention
- HIV screening and management in immigration detention
- Privacy and confidentiality.

Related instructions

- DSM - Chapter 1 - Legislative and principles overview - Service delivery values
- DSM - Chapter 6 - Detention health - Mental health policies – Minors in immigration detention - Health screening policy

Latest changes

Legislative

Nil.

Policy

This policy instruction, which is part of the centralised departmental instructions system (CDIS), was reissued on 23 November 2013 and has been completely revised.

Owner

Stakeholder and Health Strategy Section
Detention Health Services Branch
Detention Infrastructure and Services Division
National Office

Email

s. 47E(d)

Contents summary

Introduction

1 Purpose

This instruction applies to detainees, that is, all persons detained in Australian immigration detention facilities, including those who are in community detention. It outlines the screening and general health care requirements for persons over the age of 18.

The health screening policy for minors outlines the mental health screening and management for persons under 18. See DSM - Chapter 6 - Detention health - Mental health policies - Application to minors in immigration detention.

The purpose of this instruction is to:

- provide guidance to officers and stakeholders on the requirement for general health screening for detainees
- ensure that if disease is identified in a detainee the disease progression for the individual concerned is limited
- manage public health risks that may stem from the immigration detention cohort.

Additionally, any person applying for permanent entry to Australia should satisfy the health requirements specified in the Regulations.

2 General principles

It is the departmental policy that all detainees are offered health screening and assessments appropriate for their individual circumstances.

The principles that guide health screening in Australian immigration detention are that it:

- is based on expert advice from health specialists, including from the Immigration Health Advisory Group
- is aligned with national principles on refugee health screening in Australia and departmental policy
- is informed by the principles of individual and public health risk assessment
- is informed by principles of human rights
- reflects health care practice commensurate with health care in the Australian community
- is individualised and dependent on risk factors which include a person's country of origin and countries through which a person has transited or spent significant amounts of time
- is based on relevant past medical and family history, age and sex
- includes assessment and screening for any significant pre-existing mental or physical health conditions, nutritional deficiencies, physical and/or psychological evidence of torture and/or trauma and
- is responsive to health conditions diagnosed through this screening and assessment, ensuring subsequent treatment must be commenced in line with best clinical practice under the advice of the health services manager.

3 Definitions

Community detention external service provider

The provider contracted by the department to deliver primary community and welfare support to persons in community detention.

Communicable disease

An infectious disease transmissible (from person to person) by direct contact with an affected individual or the individual's discharges, by indirect means (such as by a vector) or by soil transmission.

Service providers (detention service provider)

The service provider/s contracted by the department to manage all operational and general welfare aspects of Australian immigration detention facilities or regional processing centres.

Heath care provider

A health care professional, such as a general practitioner (GP), registered nurse, or allied health professional engaged by the health services manager(HSM) to provide health care to detainees.

Health care record

A health care record is an electronic record of the detainee's or transferee's medical history, medications, vaccination history and pathology. The HSM creates a health care record for each detainee/transferee at the time of the health induction assessment (HIA). The record is managed in accordance with privacy and confidentiality requirements, and in line with their professional registration and codes of conduct. The record contains confirmation of consent (or refusal to consent to any health assessment and subsequent referral/treatment) and a note of all relevant details (including any follow-up action or referrals) relating to the outcome of any treatment.

Health induction assessment

The health assessment of a person entering immigration detention to determine their health status.

Health services manager

The health services organisation contracted by the department to facilitate access to health care for detainees.

Overview

4 Entry into immigration detention

On entering immigration detention, detainees are offered a health induction assessment (HIA). The HIA is a comprehensive health assessment undertaken to establish a detainee's health status at the time of their arrival into immigration detention. The HIA provides a basis to identify any health issues. For those issues that necessitate medical intervention, the HIA is the starting point for further relevant medical referrals or treatment for the detainee.

Illegal maritime arrivals (IMAs) undergo a triage process on arrival at the jetty to address immediate health issues. They are subject to a public health screening questionnaire and a chest x-ray as soon as practicable (but within 24 hours). A full assessment by a GP is undertaken within 72 hours.

Other arrivals into immigration detention are offered the HIA upon arrival into the Australian immigration detention system.

The HIA (apart from universal screening) must be completed within 72 hours of entry into the Australian immigration detention system.

General health assessment

5 Health induction assessment

5.1 Timeframes

The HIA process commences upon arrival at an Australian immigration detention facility and includes public health screening, general health screening and assessment as well as universal screening (mental health) components. The public health screening component of the HIA must be completed as soon as possible but no later than 24 hours after arrival into immigration detention. All of these components, excluding universal screening, must be completed within 72 hours of a detainee's entry into Australian immigration detention.

5.2 Purpose

The purpose of the HIA is to:

- provide a baseline health assessment
- identify any detainee who may be a risk to public health
- identify detainees who are unwell and
- carry out indicated, recommended pathology and x-ray testing.

The aim of the HIA is to establish the status of a detainee's health and assist with determining issues that require immediate attention and those that require ongoing health management. An HIA can also provide advice on a detainee's fitness to travel, which is valid from the date of last physical examination unless more recent health information has come to hand which indicates the person may no longer be fit to travel.

Public health screening

Public health screening must be completed within 24 hours of arrival. It is imperative that public health screening is completed within this timeframe to mitigate the risk of the spread of communicable diseases, and to enable any medical treatment required to commence as soon as possible. The public health screening includes a public health screening questionnaire and a chest x-ray.

General health screening and assessment

The HIA (apart from the universal screening) should be completed within 72 hours of arrival. This screening and assessment process is intended to establish a baseline of the detainee's health status and to identify those who are unwell, and those with physical and mental disabilities. Further investigations, testing and treatments may be required as clinically indicated.

The general health screening of the HIA includes, as a baseline:

- public health screening including public health screening questionnaire and chest X-ray
- weight/height
- temperature, pulse and blood pressure observations
- comprehensive physical examination
- medical history
- vaccination history and commencement of vaccinations / catch up schedule if required

- pathology collection – HIV, HepBsAb sAg, Hep C ab and VDRL (Syphilis)
- mental state examination (MSE)

Additionally, if clinically indicated, the following are also included:

- urinalysis (including pregnancy test if relevant)
- finger prick blood sugar level
- full blood exam (FBE) and liver function test (LFT).

Universal screening

Universal screening must be completed between 10 and 30 days of arrival. It is intended to establish a baseline mental health status for the individual and identify any mental health needs. Further information on universal screening can be found in DSM - Chapter 6 - Detention health - Mental health screening.

Tuberculosis screening and management in immigration detention

6 Principles

In immigration detention:

- all IMAs 11 years of age and older entering immigration detention undergo chest x-ray screening within 24 hours of arrival
- all detainees entering immigration detention are asked a series of clinical questions to determine their risk of having active tuberculosis. This is done to ensure that isolation can commence, if necessary, prior to the chest x-ray results being available
- all IMAs must undergo a clinical history and examination conducted by the HSM to determine their risk, if any, of active pulmonary tuberculosis prior to travel from the immigration detention facility where they were initially detained.

7 Tuberculosis testing

7.1 Overview of tuberculosis testing

All detainees have their medical history taken and are examined by a doctor to determine their risk of active tuberculosis.

A diagnosis of tuberculosis will not negatively affect a detainee's application for a protection visa.

The State/Territory public health authorities must be informed immediately if there is reasonable suspicion of a positive diagnosis of active tuberculosis and their advice sought on results.

If clinically indicated, the detainee will be placed in respiratory isolation and have further testing conducted and treatment commenced. An interpreter should be used, if needed, to ensure the detainee fully understands the situation.

In line with the department's health requirements for permanent entry to Australia, all persons 11 years of age and over should have a routine postero-anterior (PA) chest x-ray.

Arrangements need to be in place for efficient reporting of screening chest x-rays by a radiologist as well as rapid transport and testing of sputum samples as a high priority if required. Results of samples need to be relayed urgently to the HSM to allow for any cessation of respiratory isolation or referral for treatment as appropriate.

Any detainees found to have active tuberculosis will also undergo HIV screening in accordance with HIV screening and management in immigration detention.

Detainees found to be HIV positive at any time also need to be offered tuberculosis screening (in addition to the screening undertaken as part of the HDA). This precautionary step is undertaken due to the relatively high incidence of both illnesses occurring concurrently.

7.2 Screening for minors under the age of 11

Minors aged *between* six months and eleven years should be offered a tuberculin skin test (TST) if:

- there has been contact with an infected individual

- there is reason to suspect infection with tuberculosis or
- it is a requirement of the State/Territory jurisdiction.

This testing should be performed by a health professional trained in this technique and its interpretation.

Minors with symptoms suggesting active tuberculosis disease (for example, fever and cough for at least two weeks, or enlarged lymph nodes) should have a TST and a PA and lateral chest x-ray, as well as further investigations and management as indicated.

Note: TSTs are not a requirement prior to travel, unless a minor has symptoms of active pulmonary disease.

8 Tuberculosis management

8.1 Active tuberculosis

Active tuberculosis is the clinical state of disease where bacteria are replicating.

Active tuberculosis is a notifiable disease in every Australian jurisdiction. The jurisdictional public health authorities in the relevant State/Territory where the diagnosis is made (and any subsequent jurisdiction to which the detainee may be transferred) must be informed of all confirmed new cases. This will facilitate clinical management and contact tracing as relevant. Clinical management should be overseen by a specialist physician experienced in treating tuberculosis.

The results of investigations and the treatment plan should be clearly documented and accompany the detainee if they are transferred or granted a visa. Arrangements must be made by the HSM for follow up at the appropriate local tuberculosis service.

It is important that staff working in Australian immigration detention facilities are aware of the relatively low risk of transmission of pulmonary tuberculosis, with the exception of prolonged close contact (more than eight hours in a poorly ventilated space) with an infected person who is coughing.

If a detainee is to be returned to their country of origin or removed to another country after tuberculosis treatment has commenced, a supply of appropriate medications should be provided to minimise the risk of developing drug resistant tuberculosis. The detainee must be instructed, in a language they understand, of the importance of taking their medication. If possible, post arrival care must be arranged by the HSM.

Note: A detainee who is being investigated for suspected tuberculosis or who has active/infectious tuberculosis should not be removed or transferred. Detainees being investigated for suspected tuberculosis may request to return to their country of origin in which case they must be provided with adequate supplies of medication (as above).

Persons with active/infectious TB should not fly. Under exceptional circumstance, such as a medical emergency or environmental emergency, the HSM must seek approval from the Director of the Detention Health Services Operation Section prior to transporting the patient.

8.2 Latent tuberculosis

Latent tuberculosis is when the person is infected with tuberculosis but the body is managing to supress the bacteria: the person is not contagious and is not sick with the illness. Latent tuberculosis can become active and persons identified with latent tuberculosis are monitored regularly.

Screening of all detainees for latent tuberculosis is not clinically necessary, however, it is important to ensure that all persons who are at higher risk of developing active tuberculosis from latent tuberculosis are tested to allow consideration of prophylactic treatment.

Treatment for latent tuberculosis should be offered to the following groups at high risk of development of active and complicated tuberculosis:

- minors under five, provided that there are no contraindications
- detainees with concomitant immunosuppression, particularly HIV infection
- detainees on long term immunosuppressant medication
- detainees with poorly controlled diabetes or
- detainees who are malnourished with low body weight.

Note: Persons without symptoms, and who have evidence of previous infection with tuberculosis on their chest x-ray (confirmed latent tuberculosis infection) cannot transmit the infection to their contacts and should not be isolated or precluded from further travel.

It is recognised that latent tuberculosis infection management protocols vary between states/territories, and that not all persons with latent tuberculosis are routinely provided treatment in all jurisdictions. Reference should be made to the jurisdiction's tuberculosis guidelines.

HIV screening and management in immigration detention

9 Purpose

This section outlines the processes for human immunodeficiency virus (HIV) management in Australian immigration detention facilities.

HIV is the virus that causes acquired immunodeficiency syndrome (AIDS), a condition in humans in which progressive failure of the immune system allows life-threatening opportunistic infections and cancers to thrive. A person can be infected with HIV for many years without showing any symptoms.

This section regarding HIV screening and management applies to all detainees.

10 Principles

The general principles for HIV screening and management in Australian immigration detention are that:

- HIV testing in immigration detention is informed by the guiding principles for HIV testing in Australia and is aligned with nationally consistent practices on HIV testing in Australia
- HIV testing must be offered to all detainees as part of the HIA
- HIV screening information is provided in the primary language of the person being tested by a health professional supported by a trained interpreter. It is also supplemented by printed material
- Follow up testing is offered to detainees at high risk of recent or ongoing exposure
- HIV is a chronic disease with multiple options for management
- early diagnosis and appropriate commencement of treatment is imperative to improve prognosis
- education and information must be provided as a means to reduce transmission
- a positive HIV test does not preclude a person from getting a visa.

11 HIV testing

11.1 Confidential and performed with informed consent

HIV testing must be offered to all detainees as part of the HIA for persons in immigration detention.

The HSM will discuss the testing procedure, required consent and potential outcomes with the person to be tested.

Aside from the HIA, all persons in Australian immigration detention can request a HIV test at any time. This enables a person who feels they may be at risk of HIV to have access to testing over time.

Detainees have the right to refuse to have a HIV test. Any refusal to consent to HIV testing must to be documented in their health care record. The detainee must be informed that a HIV test is a requirement for permanent entry to Australia. If necessary, this information should be clearly explained through use of an interpreter.

11.2 HIV testing is a critical point to the interruption of transmission

Identification of high risk persons or persons with signs and symptoms of HIV is critical.

Appropriate testing and treatment will be provided throughout a person's detention.

11.3 Testing is of the highest possible standard and in accordance with national requirements

Appropriately qualified and accredited professionals will provide care and support throughout the HIV testing process including pre and post-test counselling support in line with nationally consistent practices on HIV testing.

Appropriately accredited health and pathology services must be used with all HIV testing.

11.4 Benefit to the detainee

HIV testing is of benefit to the detainee, who will be provided with an appropriate diagnosis and post diagnosis support (including educational support). Following a positive diagnosis, the detainee will be provided with ongoing and appropriate specialist treatment care and support.

On discharge, appropriate medical referral will be facilitated.

12 HIV management after diagnosis

All detainees with a new HIV diagnosis must be referred to an appropriately trained specialist for further assessment and counselling. Consideration should be given as to the most suitable accommodation placement to facilitate treatment plans.

If a detainee is found to be HIV positive, a further clinical assessment is conducted by the HSM to identify the stage of the disease and determine appropriate treatment options.

13 HIV prevention

Multilingual, gender specific prevention education, and access to means of prevention should be made available to all detainees, particularly persons who have been diagnosed with sexually transmitted infections.

It is standard clinical practice to counsel persons about the risks of possible HIV exposure if they are found to have sexually transmitted infections or have been diagnosed with tuberculosis. These individuals should routinely be offered testing.

All detainees have access to condoms, in privacy and without interaction with service provider staff.

All detention facilities have an HIV workplace policy and implementation plan for all staff.

Privacy and confidentiality

14 Consent

14.1 Informed consent

Informed consent must be obtained from a detainee prior to a HIA being conducted.

14.2 Consent by an adult

The HSM will explain the purpose and importance of the assessment including how the information may be used or shared with the department and external health providers, and discuss the assessment process, including serological pathology tests, to enable the detainee to make an informed decision. Access to an interpreter will be provided if necessary.

If a detainee refuses to give consent to any component of the HIA or further health screening and treatment, the HSM will record and document the refusal in the detainee's health care record.

If it is determined that a detainee may not have the mental capacity to properly look after their interests, consideration will be given to seeking the appointment of a guardian for that person. This may involve making an application to the relevant guardianship board in the relevant State/Territory.

14.3 Consent by a minor

In seeking consent for undertaking a HIA for a minor in immigration detention, the HSM will consider the minor's age and their capacity to consent to health care in accordance with State/Territory and Commonwealth legislation.

If the HSM determines that the minor does not have the capacity to make an informed decision, the HSM will seek consent from the parent/appropriate guardian for the minor, who may be a family member or a legally appointed guardian.

Informed consent (written or oral) must also be obtained from the minor for any examination, procedure or treatment whilst in immigration detention. All consent, or refusal, is to be documented in the minor's health care record. Any detainee who exercises their right to refuse to undergo a HIA must be made fully aware that this may negatively influence their ability to obtain a visa.

15 Privacy requirements

Health information is sensitive and must be managed in accordance with the Information Privacy Principles contained in the Privacy Act (1988) (the Privacy Act).

The HSM is required to protect personal health information that has been collected from detainees while providing health care.

The HSM will make the information available to departmental officers and service providers within the use and disclosure provisions of the Privacy Act.

Detention Health Operations Section, National Office coordinates requests for health information of detainees and consent processes, to ensure that the need for the request is substantiated and the appropriate consent is obtained if required. For more information contact s. 47E(d)

16 Cultural considerations

The HSM must deliver all information in a culturally sensitive way. An interpreter must be used (if required) to ensure that the detainee understands why the testing is being given and what the results will be used for. The health care provider conducting the test should ensure that the detainee understands that their privacy is paramount.

Particular care should be taken that information is presented in such a way that it does not give the perception that individuals are targeted for any particular testing or that their lifestyle choices are of any impact.

Detention Services Manual
Chapter 6 - Detention health
Health discharge assessment

About this instruction

Contents

This departmental instruction, which was previously called "Discharge health assessment and fitness to travel documentation", comprises:

- Background
- Health discharge assessment
- Consent
- Travel requirements
- Departmental terms relating to the HDA process.

Related instructions

- DSM - Chapter 1 - Legislative and principles overview - Service delivery values

Latest changes

Legislative

Nil.

Policy

This instruction, which is part of the centralised departmental instructions system (CDIS), was reissued on 23 November 2013 to provide substantive policy.

Owner

Stakeholder and Health Strategy Section
Detention Health Services Branch
Detention Infrastructure and Services Division
National Office

Email

s. 47E(d)

Contents summary

▪

Background

1 Purpose

This instruction outlines the policy for the health discharge assessment (HDA) process for detainees in immigration detention.

A HDA is conducted for all persons being released, transferred to community detention or removed from immigration detention to ensure continuity of their health care. It informs a health summary that notifies future health care providers of a person's clinical history while in immigration detention, including significant health issues, treatment received and ongoing treatment requirements.

The HDA also comprises a fitness to travel (FTT) assessment. The FTT assessment is a requirement of the *Aviation Transport Security Regulations (2005)* anytime a detainee is transported by aircraft (commercial and charter).

2 Overview

The department and detention service providers (DSP) assume a responsibility for detainees and, as such, owe them a duty of care when making decisions about their general wellbeing and care. For policy and procedure, see DSM - Chapter 1 - Legislative and principles overview - Service delivery values.

All persons entering immigration detention are offered a health induction assessment (HIA), which is a comprehensive assessment of their physical and mental health status. For policy and procedure, see DSM - Chapter 6 - Detention health- General health screening and management.

Prior to a detainee being released, transferred to community detention or removed from Australia, as per s198 of the Act, a HDA must be requested from the health services manager (HSM) by the relevant departmental business area. A HDA will be undertaken for transfer between immigration facilities only if it is clinically indicated and/or if delays in the transfer of electronic records are anticipated that would impact on continuity of care.

The HDA will:

- contain a summary of the person's health status
- indicate whether they are FTT
- detail any ongoing health issues that need to be managed and
- detail any future health appointments where relevant.

3 Scope

This instruction applies to detainees in immigration detention, which includes those detained in facility-based detention as well as those who are in community detention.

4 Definitions

Detention services provider (DSP)

An organisation/s contracted by the department to manage operational and general welfare aspects of immigration detention facilities.

Health care plan

The plan developed by the health services manager or a community health care provider to assist in managing the physical and mental health needs of detainees. It is reviewed regularly to ensure currency.

Health care provider

A health care professional, such as a general practitioner (GP), registered nurse, or allied health professional engaged by the health services manager to provide health care to persons in immigration detention.

Health care record

The health services manager creates a health care record for detainees at the time of the HIA. The record is managed in accordance with privacy and confidentiality requirements, and in line with their professional registration and codes of conduct. The record contains confirmation of consent (or refusal) and a note of all relevant details (including any follow-up action or referrals) relating to the outcome of any treatment.

Health induction assessment (HIA)

The assessment of a detainee's health status shortly after entering immigration detention.

Health services manager (HSM)

Health services organisation contracted by the department to facilitate access to health care for detainees.

Medical director

A medical director of the HSM.

Unaccompanied minor

An unlawful non-citizen child in immigration detention for whom the Minister is the guardian under the *Immigration (Guardianship of Children) Act* (IGOC Act). Under the IGOC Act, a person is generally an unaccompanied minor if they:

- are under 18 years old and
- at the time of their arrival in Australia intended to become a permanent resident of Australia and

- at the time of their arrival in Australia did not enter Australia in the charge of, or for the purposes of living in Australia under the care of, a parent, a relative who has turned 21, or an intending adoptive parent.

Health discharge assessment

5 What is a health discharge assessment

A HDA is a record that summarises the physical and mental health status of a detainee at the point of release, transfer or removal from immigration detention in order to facilitate continuity of health care.

As a part of the HDA process, the HSM or HCP is required to:

- review the health care record of the detainee being released, transferred or removed from immigration detention
- consider the medical history (including any clinical recommendations)
- document clinical findings
- facilitate continuity of care by making appointments with relevant health care providers and advising the client of these
- ensure there is an adequate supply of medication based on condition and
- establish if a physical examination is required and if so, undertake the physical examination.

The need for a physical examination can be determined by:

- consulting with specialists who have provided care to the detainee whilst in immigration detention
- consideration of any current concerns regarding the physical or mental health of the detainee
- assessing the current health risk profile and health status of the detainee
- establishing if the detainee has been physically examined within a reasonable timeframe. Note: Detainees being removed from Australia must have been physically examined by a nurse or GP within 28 days of removal
- whether there has been a material change in the detainee's clinical condition since last being examined by a nurse or medical practitioner
- the type of release (including removal) including any travel requirements
- reviewing any diagnosed medical condition (physical or mental), a disability, pregnancy, withdrawal from use of any legal or illegal substance, or whether the detainee was identified as at risk of suicide or self-harm while in immigration detention or
- considering any recent medical treatments, including any hospital treatment, surgery or psychiatric care.

If a physical examination is not required, or not consented to by the detainee, the HDA will be completed by the HSM by reviewing the information contained in the detainee's health care record. In the record it must be noted that a physical examination was not required/consented to and the reasons behind this.

If necessary, an observation of the detainee may occur to assist in determining whether there is any indication of changes to their health or wellbeing.

The HCP completing the HDA should use the standardised template agreed to by the department in all cases.

If the HSM has concerns about the physical or mental health of a detainee that may impact on their removal, transfer or continuity of care after release from immigration detention, they must inform Detention Health Operations Section of these concerns by email (s. 47E(d)) at the first practicable opportunity. Detention Health Operations Section will then convey any concerns to the relevant business areas of the department.

6 Fitness to travel

If a detainee in immigration detention, including community detention, is travelling by aircraft a FTT assessment is used to confirm that there are no health impediments to travel, including whether there are any medical considerations in-flight and/or post arrival. It is also a requirement of the *Aviation Transport Security Regulations (2005)* to declare if a person in custody has any health concerns when transported by aircraft (commercial and charter).

FTT can be determined using information from a detainee's HIA, HDA and from their medical record. A physical assessment of the detainee is required for FTT only if:

- there has been a significant change in their health since their last physical assessment
- they are being removed and more than 28 days will have lapsed since their last physical assessment at the time of removal or
- otherwise clinically indicated.

As it relates to health matters, for the purposes of the *Aviation Transport Security Regulations (2005)*, there are several questions that need to be answered. For non-escorted (security) travel on commercial airlines, advice is required as to whether the detainee has any medical conditions which may affect travel. For (security) escorted travel, a "Notice of proposed movement of person in custody" must be completed.

This information must be conveyed to the relevant airline and airport in accordance with the requirements of *Aviation Transport Security Regulations (2005)*. Available at: http://www.comlaw.gov.au/Details/F2013C00204 schedule forms - pages 304 to 308.

A FTT assessment may also be requested for land travel (train, bus and car) in certain circumstances, noting however, that it is not a legal requirement.

7 Health discharge assessment process

The HDA process is:

- 1 HDA request is received by the HSM from the department
- 2 detainee's electronic medical record is consulted
- 3 requirement for physical examination is established
  - physical examination is undertaken OR

- Physical examination is not undertaken and reasons are recorded.

- 4 relevant forms are filled out
5 follow up appointments are made where required and documented on HDA and communicated to the client
6 detainee is informed about medication requirements (with or without physical examination)
7 detainee is informed about Australian medical system (if released from immigration detention) or is informed about medical provisions in community detention.

8 When is a health discharge assessment requested

A HDA is requested by the relevant departmental business area when a detainee is to be transferred, removed or released from immigration detention. This is also applicable to detainees being transferred into or from community detention.

The HDA must be completed within 72 hours of the HSM receiving notification from the department of the need to provide a HDA.

Wherever possible, the HCP providing the HDA should be the treating clinician or have previously treated the detainee.

If a detainee is in immigration detention for a short period of time, the HIA may be used to inform the HDA, unless otherwise clinically indicated.

If a detainee is being transferred between centres, a HDA is not required. However, if a detainee is being transferred between centres and has a medical condition that is likely to require medical intervention within the first days of arrival, a hard copy of the detainee's medical record should be sent to with the detainee to the receiving facility.

For policy and procedure, see DSM - Chapter 6 - Detention health- General health screening guidelines.

A HDA is requested in community detention from the HCP when a person is being released or removed. As part of the HDA a physical assessment of the person's health may be offered to all detainees being released from community detention.

9 Who conducts the health discharge assessment

The HSM is responsible for completing the HDA or for arranging an appropriate HCP to undertake the HDA if appropriate. For example, in community detention the HSM must instruct the allocated HCP to conduct the HDA and provide documents to the HSM as well as the detainee.

If a person in criminal custody is being removed from Australia directly from a correctional facility, the HDA will be undertaken by the health professionals at the correctional facility, and the HSM would make post arrival care arrangements, if required. If the person is taken to an immigration detention facility to facilitate their removal, the HDA will be undertaken by the HSM.

10 Who receives a copy of the health discharge assessment

10.1 HSM

The HSM must ensure the HDA is appropriately stored and forms part of the detainee's health care record. The HSM must ensure that the HDA is accurate, complete and ensures that arrangements for continuity of care are made, communicated to the detainee and documented as part of the HDA.

10.2 The department

A copy of the HDA is provided to the requesting officer/party and Detention Health Operations Section by the HSM.

Detention Health Operations Section is responsible for facilitating access to the HDA by other relevant departmental business areas.

10.3 Detainee

The HSM or HCP will provide the detainee (or carer/guardian) with three copies of the HDA. Two of these copies must be in English and the other in the detainee's preferred language. The HSM or HCP must explain its significance to the detainee and what to do with the two English copies provided:

- pass one copy to the future community service provider, such as the Australian Red Cross, to ensure that service providers are informed about a person's current health status and support needs
- keep the other copy for themselves to pass on to any future health provider
- the copy provided in the detainee's preferred language is for their information.

A label is to be placed on the HDA envelope in the person's preferred language that reiterates this information.

11 Storage of health discharge assessment

The Detention Health Operations Section records and maintains all health information including HDAs in appropriately classified departmental TRIM files. The TRIM file reference can then be attached to the Compliance, Case Management Detention and Settlement (CCMDS) Portal.

The HDA (or any medical information) should not be recorded directly on the portal. However, a record of health related events (without the medical information) may be recorded on departmental systems. For example, departmental staff may record that a HDA was undertaken and the person was certified by the HSM as FTT.

12 Post discharge, transfer and removal arrangements

The HDA can form part of other transitional support plans for a detainee once they leave immigration detention. The information in a HDA assists in providing continuity of health care for a detainee.

Bridging or substantive visa

Once a person is living in the community lawfully on a bridging or substantive visa, they (and any community service providers) will be solely responsible for facilitating their own health care arrangements. The person should be encouraged to provide their HDA to their health professional in the community to assist with their ongoing health care.

If a person living in the community on a bridging visa returns to immigration detention, a HDA is not required. However, a fitness to travel assessment is necessary for commercial interstate/international air travel if this person is moved. The person's FTT may need to be assessed:

- by a community GP provider if the person is yet to enter an immigration detention facility, or
- by the HSM if the person is re-detained at a facility.

A HIA will be conducted upon receiving the person into detention.

A person being granted a bridging or substantive visa will be provided with a copy of their HDA when leaving detention. The documents will be provided as per section 10.3 Detainee.

Community detention

A person entering community detention will be provided with a copy of their HDA to pass to the allocated network provider GP. The documents will be provided as per section 10.3 Detainee.

In community detention, the HSM retains oversight of the management of a detainee's health care through the allocated community GP, who is also a network provider engaged by the HSM.

This is centrally coordinated through the Community Detention Assistance Desk (CDAD), which is responsible for arranging secondary and tertiary health care for persons in community detention.

Removal

If a detainee is being removed from Australia, the HSM should ensure that the HDA is translated in the detainee's preferred language.

While a copy of the HDA in English is provided to the detainee prior to their removal, if the HDA cannot be translated prior to removal, where possible, a translated copy should be sent to a forwarding address at the first practicable opportunity.

As part of the HDA, the HSM will make arrangements for post arrival care (such as making an appointment with a medical professional in their destination country). The HSM will also advise the department when this has been facilitated. This may include making a one-off appointment in the destination country to assist with any referrals and/or arranging for the person to obtain an additional supply of medication soon after arriving.

Transfer to an OPC

When a detainee is transferred from Australia to an offshore processing facility (OPC), they are not provided with a HDA as the HSM offshore is the same HSM as onshore. The department is provided with a comprehensive summary of the health status to ascertain the suitability of a detainee for transfer to an OPC. This includes each detainee's FTT status.

The clinical handover is progressed electronically from one facility to the next. However, as a backup, a hard copy of the health care record must be transferred with the medical escort.

Detainees will be cleared by the HSM as being fit to transfer to an OPC.

13 Post discharge medication

If a person who is released from immigration detention requires ongoing medication or is mid-way through a course of treatment, the HSM may provide up to four weeks supply of prescription medication and/or a prescription at the time of release from immigration detention. This is intended to facilitate continuity of care during the transition period while the detainee makes their own arrangements for future health care.

In addition to providing this medication, the HSM will include instructions (translated if necessary) regarding how and where to access ongoing supplies of medications and the safe storage and administration of the medication.

For unaccompanied minors, post discharge medication and the HDA will be provided to the accompanying carer when leaving immigration detention.

An unlawful non-citizen being removed from Australia will be provided with up to a two week supply of prescription medication, if required.

Note: Some medications may be classified as a prohibited drug in some destinations and/or transit countries. This may be an issue for some unlawful non-citizens being removed from Australia and must be addressed by the HSM prior to the removal.

The provision of medication for a period longer than four weeks requires the approval of the Assistant Secretary, Detention Health Branch, based on the clinical recommendation of the HSM.

Consent

14 Overview

Informed consent must be obtained from the detainee to conduct a physical examination for the purposes of completing the HDA. Note: Participation in a physical examination is voluntary and any refusal of the person to undergo an examination must not delay release.

The HSM or HCP will explain the purpose and importance of the assessment and discuss the assessment process to enable the detainee to make an informed decision. Access to an interpreter will be provided if necessary. For policy and procedure, see DSM - Chapter 4 - Communication and visits - Translating and interpreting services.

If the detainee does not have the capacity to provide informed consent because they are a minor, or because of their mental state, the HSM must then seek consent from an appropriate guardian. The requirements for a guardianship order are determined by the legislation that governs guardianship applications in each state/territory. For policy and procedure, see DSM - Chapter 1 - Legislative and principles overview - Guardianship.

15 Refusal

If a detainee refuses to give consent to a physical examination for the HDA, the HSM will record the refusal on the detainee's health care record and the HDA will be completed based on the detainee's health care record. A visual observation of the detainee may also occur to assist in identifying if there are any issues with their health or wellbeing.

16 Removal

If the detainee is to be removed from Australia, the Returns and Removals Program Support Section, Compliance Resolution Branch (and delegated guardian, if the person is an unaccompanied minor) must be informed if the detainee does not consent to a physical examination and that the HDA and FTT assessment are based solely on their health care record. The Returns and Removals Program Support Section, is contactable at s. 47E(d)

Travel requirements

17 Medical escorts

The HDA (or FTT component) may recommend the use of a medical escort to ensure that a detainee's health can be appropriately managed during travel, including during removal from Australia, transfer to a hospital or to a psychiatric facility. There are several factors which may determine a detainee's need for a medical escort, including:

- a medical or mental health condition which requires support or
- a significant history of self-harm.

The specific requirements of the service are determined and approved by the department based on clinical advice from the HSM and may include:

- advice to the department on the health risks and medical needs of the person being transported
- presence of an appropriate HCP (general practitioner, nurse or mental health professional) to provide medical care and support for the person during transportation and
- the supply of medication deemed necessary for the care and support of the person being transported.

It is the responsibility of the HSM to provide medical escort services for detainees. The recommendation of a medical escort must be endorsed by the medical director or, if the department has requested the use of a medical escort for a detainee, Detention Health Operations Section must be consulted. The use of a medical escort in all cases must be approved by Detention Health Services Branch.

These services are available 24 hours a day, seven days a week and must be provided within a reasonable timeframe from the time of request. All requests must be sent to s. 47E(d)

If there is concern that the medication could be used by the person in a manner that would either cause themselves harm or pose a threat to security, a medical escort may be required to administer the medication. In such cases, the medication will be marked in single dose packs and carried by the escort to give to the person to take when required.

In removal cases where a detainee requires a medical escort, it is the department's policy for all non-departmental medical escorts to be an Australian citizen and travel on an Australian passport that is valid for at least six months from the return date of travel, with relevant visas (if necessary). The medical escort is also required to provide their full name and passport details to the department.

The medical escort/s will accompany the detainee being removed to the initial entry port/immigration clearance point of the country of final destination.

The removal of a detainee that involves a medical escort or post-arrival health care, requires early consultation with Detention Health Operations Section (via email: s. 47E(d)

For policy and procedure, see PAM3: Act - Compliance and Case Resolution - Case resolution - Removal from Australia.

18 If a person has a communicable and/or notifiable disease

A detainee with a communicable disease can be assessed as FTT if there is a low risk of infecting another person through general contact. In the case of a person having a notifiable disease, the case must be referred to Detention Health Operations for approval prior to any travel.

If a detainee has an easily transmissible disease, such as diseases that are transmissible by air (including chicken pox and measles), the HSM may assess the person as not FTT until a later date, and advise the department accordingly. In these cases, the detainee will be treated through the HSM's relevant prevention and containment program.

If a person (for example, medical escort) has concerns about any contact they have had with a person who has a communicable and/or notifiable disease they should seek medical attention as soon as possible.

If the detainee has a current, active communicable disease, the HSM must liaise with Detention Health Operations by email (s. 47E(d)). The HDA should clearly outline:

- treatment that has been undertaken
- treatment that is required and
- if public health authorities are involved (including relevant case numbers, contact details etc.).

The HSM must also advise the public health unit if the detainee is moving states/territories, to ensure continuity of care.

It is imperative that the detainee is informed of this process and of the importance of complying with treatment protocols and follow – up care.

Note: Any communicable and/or notifiable disease identified will be dealt with on a case by case basis.

Departmental terms relating to the HDA process

19 Fitness to travel

The term fitness to travel (FTT) refers to the process used to identify the presence of any pre-existing disease or ongoing health concerns and requirements and to assess the risks these will present in relation to travel.

When travelling by aircraft, the FTT is also used to satisfy the *Aviation Transport Security Regulations (2005)* requirement to declare medical conditions for persons in custody. The requirements of *Aviation Transport Security Regulations (2005)* are available at: http://www.comlaw.gov.au/Details/F2013C00204.

A FTT assessment may also be requested for land travel (train, bus and car) in certain circumstances, to satisfy the department's duty of care; noting that it is not a legal requirement.

20 Pre transfer assessment completed

Pre transfer assessment completed (PTAC) is the term used to describe when a client has completed all required health and or security checks involved prior to transfer to an offshore processing centre.

21 Fitness to transfer

A fitness to transfer assessment advises whether a detainee is suitable for transfer from their current location to another immigration detention facility, an OPC or into the community, based on their health status.

Detainees may be precluded from transfer at that point in time if they:

- have or are under investigation for a communicable disease which may pose a public health risk
- have a health condition requiring health care that is not available in the proposed transfer location (that is, OPCs) or
- are at a stage in their treatment where relocation is not clinically recommended.

22 Removal

The term removal refers to the removal of an unlawful non-citizen from Australia to their country of origin, or to a third country where the client has a right of entry.

23 Transfer

The term transfer refers to the movement of a detainee from one location to another. This includes:

- movement between immigration detention facilities
- transfers from held detention to community detention
- transfers from an immigration detention facility to an OPC and

- transfers from an immigration detention facility to a hospital setting.

Australian Government
Department of Immigration and Border Protection

Christmas Island – Detention Operations

Transfers to Offshore Processing Centres
Standard Operational Procedures – 2013

Contents

Background

On 13 August 2012, the Expert Panel on IMA Processing released their report detailing twenty-two (22) recommendations to government. These recommendations were accepted in-principle by government and include arrangements for IMAs to be initially processed on Christmas Island prior to their transfer to s. 22(1)(a)(ii) Manus.

On 19 July 2013, the Australian Government announced a Regional Resettlement Arrangement (RRA). Under the RRA, all people arriving by boat without a valid visa from 19 July 2013 will be transferred to Papua New Guinea s. 22(1)(a)(ii) as soon as possible. Those found to be refugees will be settled in Papua New Guinea s. 22(1)(a)(ii), not Australia.

This document provides a standard operating procedure for the initial accommodation, care and processing of IMAs on Christmas Island prior to their transfer to Offshore Processing Centres (OPCs).

The primary goal of this procedure is to ensure the health, safety, security and good order of Christmas Island Immigration Detention Facilities and all people working or detained in them. Additionally, the approach to managing a higher risk operation will be based on the following principles:

- A strong and coordinated approach to operations management, intelligence gathering and issues management;
- Proactive rather than reactive management of issues through responding to intelligence quickly as a multi-disciplinary team;
- Coordinated and targeted messaging to detainees ensuring all parties are imparting the same messages;
- Detailed incident analysis to enable the identification of predictable/indicative milestones for incidents;
- Risk and emergency management reviews to ensure plans are tailored to the new operating environment;
- An approach to issues management aimed at prevention and de-escalation with the primary aim to avoid use of force or harm to people wherever possible; and
- Ensuring that any operations involving use of force are well-planned, coordinated and occur after all attempts to de-escalate a situation have been unsuccessful.

The Christmas Island multi-disciplinary team strongly believe that these approaches will minimise and diffuse situations before they escalate. Whilst not all incidents are avoidable, every attempt will be made to intervene early and prevent any further escalation.

Processing Arrangements

Processing will occur at the Processing Facility on Phosphate Hill.

It is anticipated that the following processes will be completed as a minimum dependent upon timeframes for transfer from CI:

- Initial detention, notification of regional resettlement arrangements, creation of the nominal roll, pre-transfer assessment interviews, issuing of a detention notice, transfer availability assessment (TAA) and offer of Consular assistance will be completed by DIBP.

- Health induction to include: Public Health Screening, Fit to travel certification, X-ray, Mental State Examination (MSE), vaccination, pathology collection and an examination by a General Practitioner. (IHMS)

- Welfare clothing, toiletries, meals and water are to be provided in accordance with current arrangements for IMAs. (Serco)

- Biometric capture is to be completed. (Serco)

- Intelligence gathering regarding travel to Australia which may include interview with IMA. (AFP – PSST/Customs/DIBP)

- Examination of detainee property. (Customs/AQIS)

- A modified induction to the facility/island. (DIBP/Serco/IHMS)

- Property reconciliation and detainee dossier will be completed by Serco.

Please refer to the Boat Arrivals Standard Operating Procedure for further detail and instruction on these processes.

Placement Arrangements

Placement considerations within the CI immigration detention facilities are determined by a multi-disciplinary team (MDT). This committee includes membership from the following agencies/stakeholders:

- DIBP – Detention Operations, Transfers and Regional Resettlement and Case Management;

- Serco;

- IHMS; and

- AFP.

It is integral that this multi-disciplinary approach be taken to detainee management to ensure that all aspects of an IMA's situation are considered and the best-possible arrangements implemented to support our detainees. Additionally, considering options for support arrangements in the different facilities will be integral from a risk-management perspective.

The MDT will consider such factors as:

- The demographic of detainee group – Single adult male, single female, family group or unaccompanied minor;

- Capacity on Christmas Island – does a mainland transfer need to be arranged?

- Health care and requirements of detainees;

- Security Risk Assessment (SRA) and any intelligence gathered by the Joint Intelligence Group (JIG);
- The demographic of the detainee group (to be accommodated and those in the suggested placement);
- Language and nationality;
- The good order and security of the facility; and
- The welfare and support arrangements required by detainees.

Where capacity is becoming restrictive, CI Detention Operations will liaise with National Office to determine the possibility of transfers to the mainland. It will be integral to ensure that this occurs quickly and that the factors above are considered in terms of mainland placement.

Accommodation

Christmas Island operates one Immigration Detention Centre (IDC) and four (4) Alternative Places of Detention (APODs). Difficulties that present with this model include the suitability of infrastructure, security and safety measures at the APODs for accommodation of this cohort and additionally the ability to separate boat groups until medically cleared. These both present significant risks to operations and detainee health and risks need to be minimised as much as possible.

The facilities available and the placement model outlined below also enable the implementation of cohort-specific welfare and support arrangements for our detainees.

Generally, placement of IMAs within CI facilities will be determined as follows:

Christmas Island Immigration Detention Centre (CI IDC)

It is highly recommended that CI IDC is utilised for the accommodation of all single adult males arriving under the current RRA processing model.

CI IDC has been purpose-built with hardened accommodation available for detainees who present any behavioural/self-harm concerns. Given the risks that present with the RRA cohort, it will be integral to maintain access to this accommodation to mitigate any risks of self-harm and support people in immigration detention who may have behavioural or mental health concerns. As such, White One Compound will be kept free for detainees presenting a risk to themselves or the good order and security of the facility. Additionally, where capacity allows, White One will be used to accommodate detainees immediately prior to their transfer. This allows a greater level of control and support for these detainees.

Aqua APOD

Aqua APOD will be utilised to accommodate detainees in family groups where capacity restraints exist at Construction Camp APOD. Aqua APOD may not be suitable for accommodating detainees with moderate health needs. Construction Camp APOD accommodation is preferred for detainees with moderate health needs due to the health infrastructure onsite.

Aqua APOD has a planning capacity of 300 and a surge capacity of 460. It comprises of donga-style accommodation and has limited recreational facilities. It is surrounded by an internal cyclone-style fencing and a second-skin energised fence.

Lilac APOD

Lilac APOD is currently utilised to accommodate detainees in family groups. It has a capacity of 168. Similar to Aqua APOD, it comprises of donga-style accommodation and has the same fencing arrangements.

Whilst Aqua and Lilac Compounds are not ideal accommodation for people presenting a self-harm/behavioural concern, they are the most-secure of the APODs available on Christmas Island.

IHMS will provide medical treatment to Aqua and Lilac APODs in the Aqua medical clinic.

Bravo Compound

Bravo Compound comprises of a mixture of donga-style accommodation and marquees. It has a planning capacity of 175 and a surge capacity of 300. There are a number of outdoor areas comprising of grassed-areas for sport and also covered areas. This compound will still be utilised to accommodate detainees who have not completed initial processing with the exception of anyone presenting a self-harm or behavioural management concern.

The utilisation of marquee-accommodation is on a 'last resort' basis.

Construction Camp APOD

Construction Camp APOD has a planning/surge capacity of 350. It comprises of donga-style accommodation and recreational areas that are designed for family groups but is quite adaptable and could accommodate different cohorts. This will continue to remain the primary family group accommodation. Placement at Construction Camp APOD is prioritised for detainees with moderate to high health and medical needs. All new-born detainees returning from the mainland will be accommodated in Construction Camp APOD.

The security at Phosphate Hill is low with pool-style fencing. This accommodation is also largely visible to the public and close to community recreational facilities.

Charlie Compound

Charlie compound comprises of donga-style accommodation and has a planning/surge capacity of 134. It has a large grassed area with play equipment, class rooms and covered areas for recreation. This compound is usually utilised to accommodate UAMs.

Team Roles and Welfare Arrangements

The level of services and care available to this detainee cohort will need to be tailored to their specific needs. The level of anxiety/concerns may be higher amongst this group requiring a much more considered and dynamic approach to supporting their welfare and health needs. Additionally, individual security risk assessment ratings may impact on how services are delivered and will need to be considered. These responsibilities rest with all government agencies and contractors working with detainees and clear roles are integral to ensuring we support our detainees as best as possible.

These roles are as follows:

DIBP – Detention Operations Transfers and Regional Resettlement Team (CI Transfers Team)

The Detention Operations Transfers and Regional Resettlement Team (CI Transfers Team) will continue to be heavily involved in transfer and processing arrangements. Predominantly, in relation to the regional resettlement arrangements, they will:

- Be involved in the development of operational plans, transfers, security issues;
- Select detainees available for transfer and coordinate review of the detainees by all relevant stakeholders (IHMS, JIG, Case Management, Serco, AFP etc);
- Review intelligence provided by the JIG and work with Serco and other stakeholders to manage the good order and security of the facility;
- Participate in Risk Assessment and Emergency Response Plan reviews;
- Work with Serco/IHMS/Case Management to determine placement:
- Chair Regional Transfer Committee Meetings and provide secretariat;
- Manage the processing arrangements for detainees and update the Detainee Cohort Tracker; and
- Refer any intelligence gathered to the JIG for broader dissemination as appropriate.

Please see the Regional Transfer Team Pre-Transfer Processing Checklist at: *Z:\WA\CHI\Detention operations\AD's Folder\New Cohort Planning\Templates*

Transfer Liaison Officer (TLO) responsibilities

The TLOs will be responsible for the following tasks:

- Take hard copies of all relevant documents and detainee identification cards on the flight;
- Attend CI RTC meetings;
- Work with the CI Detention Operations Transfers and Regional Resettlement Team assisting with coordination of pre-transfer arrangements;
- Work with other agencies to coordinate operations and ensure appropriate support and welfare arrangements are in place during the flight;
- Provide situational reports via text to the NatO Detention Branch Duty Phone; and
- Conduct a handover with colleagues at the airport in the regional transfer country.

Please see the TLO Operational Guide at: G:\Detention operations\RPC Transfers\TLO Guidelines

DIBP – Case Management Team

The Case Management Team will continue to have a strong role in terms of detainee welfare, pathway and vulnerability assessments. In relation to the regional resettlement arrangements they will:

- Continue to participate in multi-disciplinary teams such as the PSP and Placement Committees;
- Undertake Pre-Transfer Assessment interviews with all new arrivals and assign Case Managers;
- Participate in CI Regional Transfer Committee meetings;
- Work closely with Serco Personal/Welfare Officers to manage detainees;
- Undertake vulnerability assessments for all detainees arriving under the offshore processing arrangements; and
- Refer any intelligence gathered to Detention Operations and the JIG for broader dissemination as appropriate.

Joint Intelligence Group (JIG) (comprises of DIBP/Serco/AFP/Customs)

The role of the JIG will become increasingly integral to the success and management of operations under the regional resettlement arrangements. Under the new arrangements the JIG will:

- Produce a twice weekly situation report for National Office;
- Continue to formulate productive working relationships with all stakeholders to ensure open communication and prompt advice in relation to any intelligence;
- Formulate innovative practices to gathering intelligence;
- Become the central repository for all intelligence and issues affecting the Security Risk Assessment (SRA) of detainees;
- Liaise with colleagues and stakeholders to produce a daily situation report for distribution to the MDT's respective national offices;
- Drive the risk assessment process in relation to new operating framework;
- Provide information to the Transfer Committee on detainees scheduled for transfer to inform the operation and reduce risks;
- Attend boat reception and processing to formulate early overviews of each boat which will inform placement, in particular advising of any perceived "detainee leaders" amongst new cohorts;
- Work with the Deputy Regional Manager on issues affecting the good order and security of the facility; and

- Provide a monthly review of incidents at the facility which analyses any trends or concerns to inform targeted engagement and messaging.

Personal Officers - Serco

Personal Officers on CI will play a much more integral role to the management of this detainee cohort than previously. As the people who spend most time with our detainees they will be expected to:

- Develop a rapport with their detainees and an understanding of their concerns/issues;
- Complete the detainee's Individual Management Plan (IMP);
- Provide information relevant to the Security Risk Assessment (SRA) through provision of information to officers completing the report;
- Assist detainees in managing these issues by referring them to the relevant provider (e.g. mental health team) for assistance as required;
- Work with detainees to ensure appropriate activities etc. are provided which keep them engaged;
- Identify and refer detainees to the Psychological Support Program (PSP) Committee who may require a higher level of assistance;
- Participate in the relevant committee meetings and contribute in relation to their detainees providing advice/recommendations on detainee management and support; and
- Working with other agencies and contractors to implement support plans and engage with detainees to ensure the implemented mechanisms are having the desired effect.

Welfare Officers - Serco

Welfare Officers provide an additional level of support to Personal Officers and assist in the management of detainees identified as at risk of self-harm or who present behavioural management issues. They participate in meetings of the MDT and provide guidance on detainee issues and service provision to address these issues.

International Health and Medical Services - Mental Health Team (IHMS MHT)

The IHMS MHT will play a critical role in supporting people in immigration detention. Given the new arrangements it can be anticipated that a higher level of care will be required. In addition to current IHMS services, it is suggested that:

- The MHT will provide additional services within the compounds of the IDC including group counselling sessions on relaxation, sleep therapy and stress. NB: subject to risk assessment ensuring no danger to staff;
- Provide advice to stakeholders recommending engagement/support strategies;
- Try to allocate the same team members to individual compounds to allow them to build a rapport with detainees and staff working in that compound; and

- Provide advice regarding suitability of transfer from a mental health perspective including any torture and trauma issues.

IHMS – Physical Health Team (IHMS PHT)

The IHMS PHT will also play a critical role in ensuring that detainee physical health care needs are met and that Fit to Transfer, pathology test results and medical discharge arrangements are managed in a timely manner to support transfer of detainees.

Whilst every measure will be taken to reduce/mitigate incidents of self-harm, given the potential levels of anxiety, this may also create additional pressures on the PHT.

Approvals for additional staffing will be made in a timely manner to ensure that IHMS have the capability to recruit and retain staff to support our operational requirements.

Serco - Activities/Excursions

The different dynamics of this detainee cohort will be taken into consideration in terms of activities and excursions. Strong media presences on island will also impact on the ability to conduct external excursions noting that the preference is for detainees not to be exposed to media. This is particularly important in that the identification of detainees in the media can cause problems for family members back home and also raise *sur place* claims. As such, while the preference is for activities and excursions continue, they will need to be risk assessed by the Multi-Disciplinary Team (MDT) prior to approval.

In this context, activities within the facility will have an increased focus with the aim of keeping detainees busy, engaged and providing educative opportunities. Increased consideration by Serco of diversifying the activities provided within the facility and particularly the compounds will be a priority. Given the cohorts will only receive scheduled time in the Greenheart area; activities within the compounds will be required.

A sub-committee will be established to review current activity programs and determine innovative activities that can be provided to detainees in the compounds and also review excursions to minimise any risks to staff and detainees.

Serco – Individual Management Plans (IMPs)/Security Risk Assessments (SRAs)

The utilisation of IMPs/SRAs will become an important tool in the management and support of detainees at CI IDC. Whilst it is anticipated that detainees will not be accommodated longer-term, the focus on support, engagement and risk mitigation will mean that these will become important tools.

It will be imperative to ensure that these documents are not just a “tick and flick” but rather provide useful information to various stakeholders in the support and management of people in our care.

Transfer Arrangements

Identifying detainees for transfer

Following their arrival and detention on Christmas Island, DIBP National Office will advise the Regional Transfer team of the flight schedule and cohort information for upcoming chartered flights from Christmas Island to Offshore Processing Centres. Following the collection of a nominal roll for all detainees on a SIEV, the Regional Transfers team will work with DIBP National Office to build transfer lists by matching detainees with the cohort profile for each Offshore Processing Centre.

As such, the selection of IMAs for transfer to an Offshore Processing Centre (OPC) by the Transfer and Regional Resettlement Team will be based on a range of factors including:

- **Most recent arrivals**

Service provider advice indicates that this reduces risk of negative behaviour and will provide for safer transfer arrangements for IMAs and staff.

- **Completion of processing**

No IMAs will be transferred to an RPC prior to the completion of all processing.

- **Those who choose to return home after notification of transfer whilst on CI**

IMAs who choose to accept an Assisted Voluntary Return (AVR) prior to notification of transfer, and whose return to their home country is imminent, will not be considered by the CI Transfer Committee. DIBP Case Management will liaise with the International Organisation for Migration (IOM) and DIBP Removals Officers to facilitate their return.

- **Similar cohort – support/resources**

Nationality and language need to be considered in terms of detainees supporting each other and also in terms of resource availability – interpreters, culturally appropriate food etc.

- **Fit to Travel and Transfer**

The fit to travel and transfer health vulnerability assessments will drive our selection of detainees for transfer. This includes consideration of:

  - Whether a detainee has a temporary health condition which precludes transfer until resolved;
  - Health factors including consideration of whether the IMA can be appropriately supported at the OPC;
  - A policy of not separating primary family groups;
  - Vulnerable groups such as unaccompanied minors, single females and others resulting from assessments.

Those assessed as not being suitable for transfer to an OPC or to be considered as exempt from RRA arrangements, will remain on Christmas Island pending advice from DIBP National Office regarding alternative placement.

- **Pre-transfer Assessment conducted by Case Management**

Consideration of vulnerability factors such as:

  - Cohort – unaccompanied minors, single females and family groups;
  - Those with familial ties to Australia (in detention or community);
  - Protection claims against the country the OPC is located;
  - Intellectual capacity; and
  - Age.

- **Risk assessment**

Intelligence gathered from the CI Joint Intelligence Group (JIG) surrounding factors such as: attitude to transfer arrangements, behaviour in immigration detention, risk to the good order and security of the facility and other risks as they arise.

Consideration will need to be given to networks and associated factors within the boat as this could impact on attitude to transfer if friends are separated etc.

- **Cohort – Family groups (FAMs), Single Adult Males (SAMs), Single Adult Females (SAFs) and Unaccompanied Minors (UAMs)**

Consideration of whether there is capacity at the OPC for any of these particular cohorts will also drive transfer selection processes.

- **Availability of accommodation at OPC**

Unaccompanied Minors (UAMS) and young adults

In order to mitigate the risk of sending UAMs to OPCs, the Age Determination team on Christmas Island will conduct a triaging report for submission to both the Director of Detention Operations on Christmas Island and Case Management Director, and Case Management Assistant Directors for consideration at the CI RTC.

This triaging is not designed to replace the existing Age Determination process, but to add rigor and supplement the existing Age Determination process. Under the triaging process, the CI Age Determination Assistant Director will conduct brief and informal interviews with all detainees claiming to be Unaccompanied Minors, and all single detainees claiming to be between the ages of 18 and 20 inclusive.

The aim of this preliminary interview is to triage those detainees who may require further investigation via a referral to the Age Determination team for an opinion about whether they are over the age of 18 or under the age of 18. Where the Age Determination Team are satisfied that a person has provided information consistent with their claimed status as a minor they are not

required to undergo a formal age determination interview and the department will treat such persons as a minor. Where there are concerns about the claims made by a person to be a minor they will be referred for a formal interview where an assessment is made on their status as an adult or a minor.

The purpose of triaging single detainees between the ages of 18 and 20 is to ensure persons who may actually be under 18 are not inadvertently transferred to an OPC as adults. Where the Age Determination Assistant Director is satisfied that the detainee is indeed an adult and no issues related to age are raised, there is no need for this cohort to undergo a formal age determination assessment. Where there is doubt, the detainee should be formally assessed before being considered for OPC transfer.

As a further safeguard, it has also been agreed that the Age Determination Assistant Director and the Director of Detention Operations on CI will provide a final vetting of all persons proposed for transfer who have undergone an age determination assessment or been the subject of triaging. This is intended to mitigate the risk of a UAM inadvertently being transferred to an offshore facility that currently has no capacity to manage such persons.

Completing the Transfer List

Once the CI Transfers Team have completed the assessment of the list of detainees, the list will be distributed to the CI RTC prior to transfer to ensure stakeholders have time to review detainees and record their feedback for the meeting. This feedback will be incorporated into the transfer spreadsheet prior to the meeting to ensure an efficient approach to reviewing detainees for transfer.

Ensuring there is contingency should some detainees not be approved for transfer

The CI Transfers Team will ensure that there are at least an additional 10% of detainees on the transfer list to ensure there is some contingency should detainees not be approved for transfer by the CI RTC or should they not be approved under the Transfer Availability Assessment process.

Convening the CI Regional Transfer Committee (CI RTC) to consider detainees for transfer

The Director of Detention Operations will then convene the CI RTC. The objective of the committee will be to determine that appropriate arrangements are in place to support IMAs upon arrival at the Offshore Processing Centre and that vulnerability and other factors are considered.

The Regional Transfer Committee will comprise of:

- Director of Detention Operations (Chair)
- IHMS
- Serco
- DIBP Case Management
- Australian Federal Police (AFP) representative
- Joint Intelligence Group (JIG)

This RTC will allow a full consideration of all factors relating to IMAs subject to transfer to Offshore Processing Centres by encouraging multi-disciplinary consideration and recommendations as to who should be subject to transfer.

Additionally, through consideration of intelligence and other factors, the RTC will be able to ensure that appropriate contingency arrangements are implemented to ensure the good order and security of the facility and the safety of everyone within it.

Under the legislation, detainees whose Pre-Transfer Assessment (PTA) or health assessment indicates there are vulnerabilities may not be transferred. These detainees will be placed in mainland facilities dependent upon their vulnerability and the services required. The PTA is finalised on the day of transfer as Case Managers must interview all detainees scheduled for transfer ensuring they respond to the final four (4) questions on the PTA form.

The RTC will meet to review detainees and make recommendations as whether or not a detainee will be transferred. They will take into account a range of factors in developing the list such as:

- Length of time on Christmas Island ensuring that the detainee has finalised processing;
- Security Risk Assessment and behaviour whilst on Christmas Island;
- Personal/Welfare Officer interactions and opinion on detainee reaction to notification of transfer;
- Any Physical/Mental health concerns;
- Any concerns regarding the reaction of other people in immigration detention (friends/agitators in the facility etc); and
- Any other concerns that may impact on affecting the transfer or the good order and security of the facility.

Preparation for the transfer

Once the final transfer list has been approved, the requisite preparations for transfer need to be made. These include:

- Identification of the Transfer Liaison Officers (TLOs) who will travel with detainees on the transfer;
- Conducting a briefing on operational arrangements for all staff involved prior to transfer;
- Liaison with the airport to ensure airside access for staff;
- Completing passenger cards for all detainees and staff travelling;
- Ensuring Detention Service Provider assessments are finalised;
- s. 22(1)(a)(ii) ICAO documents for Manus transfers;
- All relevant documents are sent to s. 47E(d)

Operational arrangements for the transfer of single adult males (SAMs)

Once the detainees have been approved for transfer and the operational plan has been approved, detainees will be moved into the Support Compound on the day of their transfer. They will remain here until their processing is complete and they are ready for transfer. The compound will be monitored closely by Serco Personal Officers and the Joint Intelligence Group who will advise of any issues arising or any change in compound mood.

Non-compliant detainees will be separated from compliant detainees and engaged with by Serco to allay any concerns they may have. Please refer to Serco Operational Plan for further detail on these arrangements.

Operational arrangements for the transfer of family groups (FAMs)

Family groups will be processed in the Property/Visits area of CI IDC. This area allows for a large outdoor play area for minors and Serco activities staff will be present to entertain minors while their parents are notified of transfer and relevant interviews are completed.

Additionally, to minimise any exposure for children, parents will be offered the opportunity to have their children entertained by activities officers while they meet with DIBP to discuss their immigration pathway.

As with the SAM cohort, any non-compliant or upset detainees will be separated and engaged with to ensure their concerns are addressed and mitigate exposure for minors.

Additionally, Case Managers must conduct a Best Interests of the Child determination which is considered by National Office (AS Children and Community Support Branch).

Please refer to Serco Operational Plan for further detail in relation to this processing.

Pre-operational briefing

Serco will manage a pre-operational briefing with all stakeholders at least thirty (30) minutes prior to the intended notification time. This briefing will enable all stakeholders to have their roles reaffirmed and ask any further questions.

Requests for access to legal advice

In the context of transfers to a regional processing country under section 198AD of the Act, once an officer has commenced removing a detainee from a detention facility for the purposes of taking the person to a regional processing country, the person is taken to be no longer in immigration detention (subsections 198AD (3) and (11) refer). As a guide, the process of removing a person from a detention facility after they have been identified for transfer may be taken to have commenced at the point at which they are being readied for removal from the facility.

If a transferee requests access to legal advice at or after this point, while section 256 of the Act does not apply, if it is reasonably practicable in operational terms to provide facilities to enable the person to contact a lawyer, then those facilities should be provided. What is reasonable will depend on the circumstances including what is occurring operationally and whether facilities are readily available having regard to the particular operational environment.

The removal or transfer of a person from Australia is not prevented or delayed by a person's inability to make contact with the legal representative (for example, where the legal representative contacted was unavailable or where the person is waiting for a message to be returned by the legal representative).

Notification to detainees of transfer

Given the risks to the good order and security of the facility, it is recommended that notification of transfer to detainees occurs on the day of the transfer. Detainees will be advised individually of their transfer by Case Managers in the processing area. Family group notifications will differ to SAMs in that parents will be offered the opportunity to meet with DIBP while their children are entertained by activity officers.

Detainees being transferred to Manus will also be addressed by an IHMS nurse who will offer them medication to address the risk of malaria. At lunch time a doctor will return to dispense this medication to any detainees accepting the offer.

Serco will ensure appropriate staffing levels to maintain the safety of staff and the good order and security of the facility. A mixture of Emergency Response Team (ERT) and Client Services Officers (CSOs) will be present during the transfer operation.

An IHMS nurse will be available in the sterile zone of the compound should any medical issues arise during the notification. This nurse will also be available at the processing area. Additionally, a Mental Health Team member will be on-call and available to attend.

Transporting detainees to the Processing Area

Once notification has occurred, detainees will be provided with bags and given the opportunity to pack their personal belongings. They will then be transported in groups of 10 to the Support Unit which will be used as the processing area.

Any non-compliant detainees will be transported to the processing area separate to the main group. There are established protocols for the use of force and Serco will be responsible for trying to diffuse the situation and negotiate prior to any use of force considerations.

Processing detainees for transfer

Upon arrival at the Support Unit, single adult male detainees will be issued with a wrist band stating their boat number and a sticky-label upon which their given name will be written, and attached to their clothing. They will then be placed in a secure area on one side of the processing area where they will be advised by DIBP of the processes that will occur during the day.

Following this, they will be taken individually to a private area to change into new clothes. Their old clothes and any jewellery items will be placed in the bag with their other property.

Detainees will then go through the property discharge process with their property being signed over to the Transfer Liaison Officer. The bags will be transported to the airport with the detainees and placed directly into the aircraft hold.

Detainees will then go through the Customs clearance process in the presence of the Transfer Liaison Officer.

Detainees will then be pat searched by a Serco officer prior to transfer into a sterile area. This search will be observed by the Australian Federal Police (AFP).

Ensuring relevant documents are sent to National Office

All relevant documentation utilised for the purposes of a transfer to an offshore processing centre needs to be stored in the group drive as soon as reasonably practicable. This includes processing documents such as Detention Notices, Detention Services Provider (DSP) assessments, committee reports and detainee lists, pre-transfer assessments, visa applications, fit to fly assessments and other documents. These documents also need to be emailed to s. 47E(d) pending their access to…… Once this is completed all documents need to be scanned and saved in the group drive so that they can be accessed in the event they are required.

Transfer to the airport

When all detainees have completed the process they will be placed on the transport to the airport approximately one (1) hour prior to scheduled aircraft departure. They will be accompanied by the Transfer Liaison Officer, AFP representative and Serco transport and escort and ERT staff.

Any non-compliant detainees will be transported to the airport separately to the main group. There are established protocols for use of force and Serco will be required to ensure that they try to diffuse the situation and negotiate prior to any use of force.

Detainees will be taken airside at the airport to be transferred into the custody of the AFP escorts. This will be conducted with an airside transfer involving a face-to-photo check.

At this time, the IHMS nurse who has been present with the detainees throughout the process will conduct a handover with their counterpart who will be escorting the detainees to the Offshore Processing Centre. The escorting nurse will also be provided with all detainee dossiers and medications at this time for handover at the Offshore Processing Centre.

The Transfer Liaison Officer will also be responsible for ensuring that he or she is familiar with the contents of the TLO Operational Guide.

The Transfer Liaison Officer will also have any relevant documents or files required to travel with the detainee from an immigration perspective. These will be recorded on the Property Handover Record.

These documents will be retained for any final reconciliation and also to ensure there is a record in the event of any future disputes.

s. 22(1)(a)(ii)

Transfers to Manus IRPC

Transfers to Manus can involve family groups or single adult males. The following are arrangements specific to Manus transfers:

- The list of detainees must be submitted to National Office (Regional Operations Team) so that the Papua New Guinean government can approve the list;
- The final list of detainees must be from the PNG approved list and provided to the PNG government at least forty-eight hours prior to transfer;
- Detainees are issued an ICAO document rather than an RPC identification card;
- People scheduled for transfer need to also be informed of risk of malaria and offered Malarin on the day of transfer (during processing). Anyone refusing Malarin will still be transferred;
- A copy of each transferee's property record needs to be provided to the PNG government by the TLO upon arrival;
- Due to strict quarantine regulations all detainees footwear must be clean and free of dirt etc upon arrival to PNG;

- No detainees with children under the age of seven (7), single adult females or unaccompanied minors can be transferred at this time.

Arrangements within the facility post-transfer

Given the risks within the immigration detention facility post-transfer to an offshore processing centre, the Serco operational order provides for an increased presence within the facility. This will allow for a much higher level of engagement and interaction with detainees to ensure that the mood of the compound is monitored closely and that any issues are reported and managed proactively.

There is an additional presence of Emergency Response Team (ERT) staff onsite. Additionally, the Australian Federal Police (AFP) contingent on Christmas Island is well-briefed on operations and available to respond should it be required.

International Health and Medical Services (IHMS) are also well-briefed on operations and are prepared to respond should it be required.

The mood of the compounds post notification of transfer will be monitored in terms of safety of staff and until an assessment has been made of the mood of the compound.

Work Health and Safety Arrangements

The new operating environment will provide a higher degree of challenge for our teams, as such, a sub-committee was established to review arrangements and ensure that appropriate management support and monitoring arrangements were implemented to ensure the work health and safety of staff.

As a result, the following arrangements are implemented/continued:

- Supervisors closely monitor and engage with their teams reporting any issues of concern to the management team and the Employee Assistance Program Counsellor on-site;
- Any issues are dealt with swiftly and appropriate follow-up considerations are implemented;
- EAP has also identified that teams which have a higher number of shorter term 'fly in fly out' staff are likely to feel more stress due to the added pressure of constantly training and building new relationships with people, so management should be conscious of this;
- Work Health and Safety presentations to be reviewed to ensure that they cover the new operating model and contingency arrangements during induction;
- Serco should increase the promotion of its peer support program, this can be done at induction, with posters and with peer support staff being encouraged to discuss their role more with their colleagues;
- Both Serco and DIBP's EAP counsellors to hold a weekly, interactive session with staff on relevant topics, such as identifying and managing stress, how best we can support each other and any other topics that EAP/managers think might be useful;
- Managers should continue to have informal 'wellness' checks with each of their staff members on at least a monthly basis;

- Managers to promote new initiatives such as the colour coding scheme which will help staff quickly identify the risk rating of various compounds; and

- Weekly email update from the Regional or Deputy Regional Manager about transfers, issues that have arisen and any other relevant information. This strategy is aimed at promoting a sense of inclusiveness so that team members who are not directly involved in the operation and implementation of the new policy are also aware of what is happening. From a practical safety perspective this is also important.

Post-transfer arrangements

The Transfers and Regional Resettlement Team on Christmas Island will be responsible for updating departmental systems once detainees have departed Christmas Island.

All relevant documentation will be saved in TRIM by the WA IMA Support Team.

Australian Government
Department of Immigration and Border Protection

Offshore Processing Centres: Nauru and Manus Island

Review of Welfare and Case Management Services

people our business

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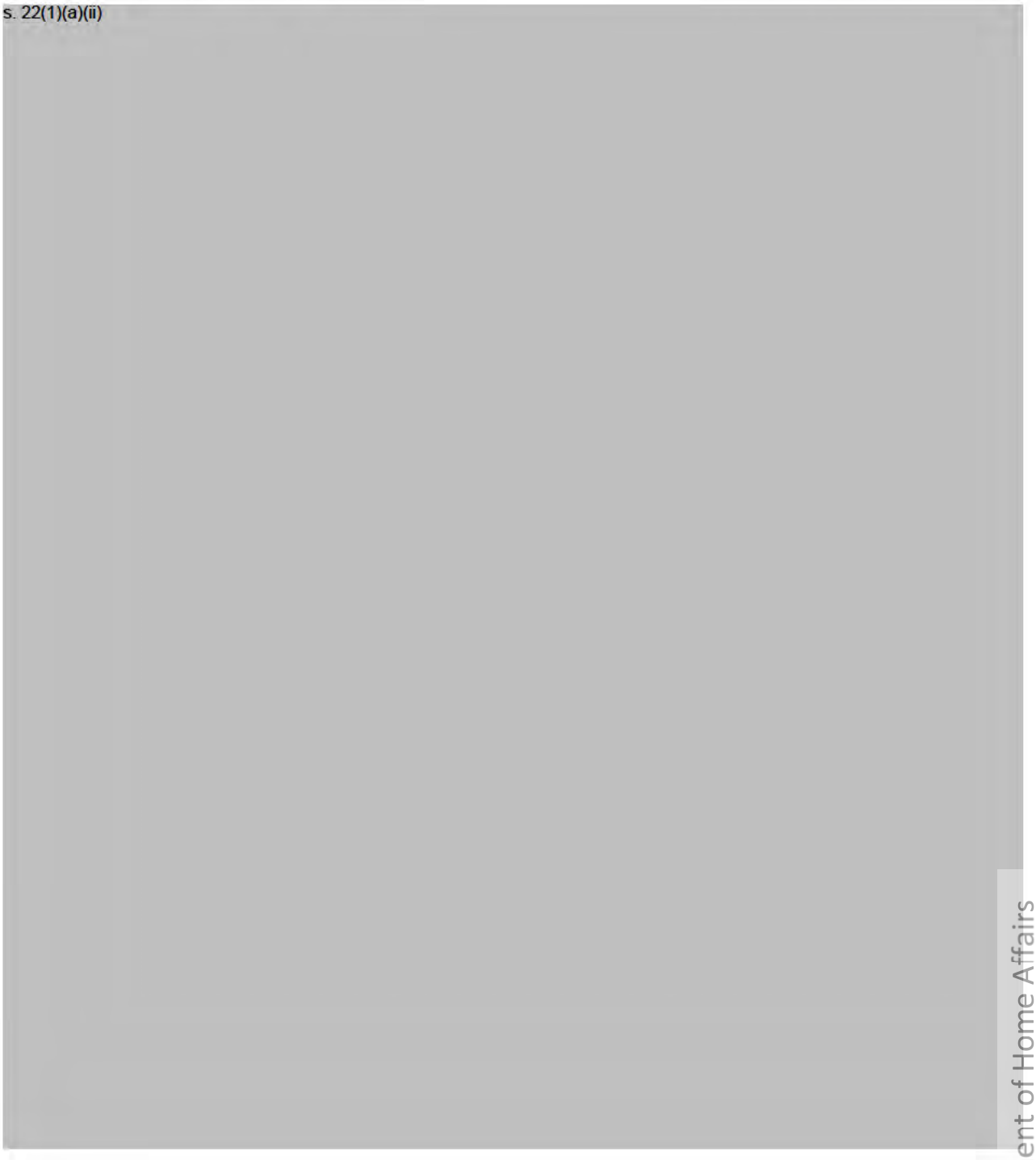
s. 22(1)(a)(ii)



1.0 Introduction and Terms of Reference

Since the establishment of Offshore Processing Centres (OPCs) s. 22(1)(a)(ii) Manus Island (Papua New Guinea), the provision of welfare services has been delivered under a separate contract by a welfare sector agency. The Department of Immigration and Border Protection (the Department) has introduced a new model to deliver services at OPCs, consolidating the delivery of welfare services under one contract with garrison services for both centres for all Single Adult Males (SAMs). Transfield Services Australia has been appointed under a 20-month contract to deliver services under this consolidated model. Services for Families, Unaccompanied Minors and Single Adult Females are still under the dual service provider model, with Transfield providing garrison services and Save the Children Australia (SCA) providing welfare services.

A Review Team was established to review Transfield's model for the delivery of welfare services at the OPCs, to provide an assurance mechanism for welfare services delivered and to ensure the availability and delivery of appropriate care and welfare services suited to the individual welfare and wellbeing needs of the transferees. Review of welfare services provided by SCA was not within the scope of this review, however the Review Team suggested that a review of SCA services be conducted.

Review Team: s. 22(1)(a)(ii) – Director, Case Management & Status Resolution, South Australia.
s. 22(1)(a)(ii) – Assistant Director, Case Management, Victoria.

The Review Team focused on the welfare service procedures and systems implemented by Transfield on s. 22(1)(a)(ii) and Manus Island (transition from G4S and The Salvation Army) around the design of care and case management plans and delivery of services under the contract which include:

- Recruitment and training of welfare staff, including pre-deployment preparation and support;
- Design and implementation of care plans or Individual Management Plans (IMP) for the transferees to meet their individual welfare and wellbeing needs within the OPC environment;
- Promoting access to services identified under the Individual Management Plans (IMP) which include the delivery of appropriate programs and activities suited to the needs of the transferees as well as the environment;
- Liaison and engagement with OPC service providers in relation to the monitoring of care arrangements and the sharing of information to inform transferee care.

The Review Team sourced information directly from Transfield and other service providers including the observation of activities relevant to the appropriate management and care of transferees within the OPCs. A number of discussions were held with local staff which focused on their understanding of the welfare service model through appropriate pre-deployment training as well as on-the-job support

This report documents the Review Team's findings and recommendations to assist in maintaining an appropriate level of service which caters for the individual welfare needs of the transferees and identification of any improvement areas. All recommendations were discussed with Transfield and

other service providers to ensure that they are achievable within the service scope of the contract as well as within the resource availability of the OPC environments and host countries.

2.0 Executive Summary & Recommendations

2.1 Executive Summary

The Review Team commenced its review on 12 March 2014. The initial stage involved meeting with Senior Managers from Transfield at its Sydney headquarters to discuss planning, recruitment and training for the case management roles to be established at both the Manus Island and Nauru Offshore Processing Centres. The Review Team then travelled to Manus Island on 14 March 2014 where initial discussions were held with case management and operational staff. s. 22(1)(a)(ii)

[redacted] to Manus Island from 30 March until 9 April 2014.

Overall the Review Team was impressed by the processes that had been implemented by Transfield and commend all Transfield staff on their willingness to engage in the review and their reception to the feedback provided.

Findings

Distinction between 'welfare' and 'case management'

The terms 'welfare' and 'case management' appear to be used interchangeably and does require some clarification. The experience of the Review Team is predominately in case management within the Department however comes with experience in working in a detention environment and thus, an understanding of welfare service provisions in the onshore system. The title case manager is applied to officers who are responsible for resolving the immigration status of asylum seekers in both held and community detention environments, and those in the community on bridging visas. Within the context of the contract with Transfield, the title of case manager is assigned to officers undertaking a welfare role for those accommodated at OPCs on Manus Island s. 22(1)(a)(ii) with no status resolution focus. Transfield case managers are solely responsible for managing the welfare of transferees to ensure they remain engaged with services and support to maintain their health and wellbeing whilst at the OPC. As the title of case management has already been applied and has been in use for some time, it may not be practical at this stage to change it to Welfare Management/Welfare Officers. For readers of this report however, it is important to recognise that Transfield case managers have no influence over the status resolution of the individuals they case manage.

The manuals developed for Transfield case managers state that:

> The purpose of the 'case management and meaningful activities model is to ensure the well-being of transferees so that they can remain engaged with their status resolution process. These services form part of a holistic, integrated approach to maintaining the wellbeing of the centre and its people,' (*Case Management in Offshore Processing Centres*, Transfield Welfare Services, 2014).

Recruitment and training of welfare staff, including pre-deployment preparation and support

Recruitment of welfare staff was well advanced at the time of the review. The recruitment process is outlined in detail in the body of the report. The process is quite comprehensive and application levels have been high. It is anticipated that a pool of suitable candidates will be maintained to assist in managing attrition rates. At the time of the review, formal training for case managers had not yet commenced. The Review Team has provided recommendations regarding the training materials and supporting documentation for case managers. A copy of the recommended changes to the documentation was provided separately to Transfield to assist in finalising the training manuals for case managers. These suggested changes were discussed directly with MDA at a meeting in Brisbane on 21 March 2014 with both MDA and Transfield very open to the feedback and recommendations.

The Review Team provided early feedback to assist with the timely implementation of the full suite of case management training for staff at both locations in order to prevent inconsistent practices amongst case managers who come from a variety of different backgrounds and disciplines. The Review Team is of the view that case managers need to be supported with structured and detailed procedural documents to ensure a holistic understanding of their role as case managers as well as the environment they work in.

Design and implementation of care plans or Individual Management Plans (IMPs) for the transferees to meet their individual welfare and wellbeing needs within the OPC environment

In terms of the case management model, Transfield appears to have a good grasp of its obligations in relation to the appropriate design of care plans and subsequent reviews to ensure the individual circumstances and needs of the transferees are considered and managed accordingly. The Review Team was provided with copies of IMP from both OPCs and was impressed with the level of detail contained. It is noted however that due to the environment and the location of the OPCs, options for managing individual welfare needs are relatively limited, particularly in terms of excursions and activities outside the centres. IMP monitoring appears to be well embedded within the case management processes. The Review Team was not able to witness any IMP reviews as transition had only just occurred.

Promoting access to services identified under the Individual Management Plans (IMP) which include the delivery of appropriate programs and activities suited to the needs of the transferees as well as the environment

At the time of the review on Manus Island, programs and activities were severely limited as a result of the recent disturbances at the centre. Locally-engaged staff were unable to enter the compounds and case management staff were assisting with the delivery of basic welfare services such as internet and canteen. It was noted that a reintegration plan had been developed and was in the early stages of implementation to address this issue. Until full reintegration is achieved, it is unlikely

that the appropriate level of programs and activities can be provided. This will have a direct impact on transferees and their ability to engage in meaningful activities.

s. 22(1)(a)(ii)

The Review Team met with CS.net in Brisbane and was briefed on the ability of their IT system to allow self-nomination for activities by the transferees and greater recording and reporting capacity within the system to track engagement in programs and activities. The Review Team supports the introduction of this enhanced capability as soon as practicable. The introduction of an IT solution to allow transferees to have greater engagement in booking activities will greatly assist in the promotion of welfare services available in the area of programs and activities and provide more time for welfare staff to engage with transferees on an individual level.

Liaison and engagement with OPC service providers in relation to the monitoring of care arrangements and the sharing of information to inform transferee care

Whilst this review was conducted shortly after transition, it was evident that good lines of communication were being developed at an early stage, however, information sharing provisions between service providers required further development. The Review Team's discussion on information sharing provisions with service providers particularly focused on the sharing of essential health information between Transfield and IHMS to assist in informing IMPs and general management of transferees. s. 22(1)(a)(ii)

The Review Team worked with both IHMS and case management to provide some guidance around the level of information that could reasonably be expected to be shared regarding transferees. Despite this, IHMS raised general concerns given the lack of an appropriate consent process upon transferee arrival. Therefore, the Review Team thought it appropriate to consider a separate consent process as part of the transferee induction process which would assist in the development of appropriate IMP which consider individual health needs. The Review Team would encourage the development of a 'terms of reference' or protocols for each of these forums to ensure consistency in approach.

2.2 Summary of Recommendations

The recommendations can be broadly grouped into six separate areas – Terminology, Procedures, Supporting Documentation, Information Sharing and Role Classification.

Terminology

Recommendation 2: Transfield to ensure that a clear definition of a case manager under the welfare service model is provided to ensure that they are aware that they do not advocate or engage in status resolution discussions with transferees and ensure their training program reflects the same.

Recommendation 3: Transfield to ensure that the use of the term 'detention' is removed from all policy and procedure documents and ensure their staff are aware of the correct policy terms, being 'Offshore Regional Processing' when referenced within Australia and 'Regional Processing Centre' when referenced from s. 22(1)(a)(ii) Manus Island.

Recommendation 4: The Review Team recommends that Transfield reconsider the use of the term 'advocate' in their training and policy/procedures documents given the potential misinterpretation in the context of working with transferees.

Procedures

Recommendation 16: The Review Team recommends that Transfield consider an appropriate caseload allocation model which considers the level of case management intensity and engagement of transferees and ensures an equal distribution of complex workloads amongst case managers. The *Case Management Risk Identification Tool* could be used to assist in identifying case complexities and therefore, inform the allocations model.

Recommendation 17: The Review Team recommends that Transfield, together with the Department, clarify the position around timeframes for review of the IMP and expectations in relation to review mechanisms.

Recommendation 18: The Review Team recommends that following clarification of the position around timeframes, and the mechanism for IMP reviews, that Transfield consider the use of the Complex Behaviour Meeting (CBM) as a review mechanism to allow for service provider input to inform the review.

Recommendation 21: The Review Team recommends that Transfield, together with the Department, consider a new consent process on arrival at the OPC to cover the exchange of basic medical information between service providers to assist in the appropriate management of transferee needs.

Recommendation 23: The Review Team recommends that Transfield undertake further discussion with IHMS regarding the establishment of a protocol for the sharing of information to assist in informing the management of transferees at OPCs, particular on arrival to an OPC. This includes the establishment of an escalation process for follow up of medical referrals.

Recommendation 29: The Review Team recommends that Transfield Security consider formally expanding the Complex Behaviour Meeting (CBM) to include a focus on discussing other vulnerable transferees, not just from a behavioural perspective, to enable the sharing of information between service providers to ensure the holistic care of transferees in the OPC environment. Transfield Security may wish to consider the development of a 'terms of reference' to ensure a clear understanding of the use of this meeting and expectations of stakeholders in relation to the provision of information sharing. This could be raised at the Weekly Departmental Review meetings (WDR) to ensure stakeholder agreement and formal sign off.

Recommendation 30: The Review Team recommends that Transfield liaise with the Department regarding the establishment of a protocol for changes to transferee biodata information. The Review Team has highlighted the issues surrounding substantial name changes and changes to date of birth. All substantial biodata changes should only be made with approval from the onsite DIBP and supplemented with appropriate evidence i.e. identity documents.

Recommendation 35: The Review Team recommends that priority be given to ensuring all transferees (on Manus Island) have a PNG Health Clearance so they can participate in excursions.

Recommendation 36: The Review Team recommends that once locally engaged staff have been reintegrated back into the compounds on Manus Island, continual review of P&A be undertaken with transferee input into both formal and transferee-led activities where possible.

s. 22(1)(a)(ii)

s. 22(1)(a)(ii)

Recommendation 46: The Review Team recommends that consideration be given to the deployment of a DIBP Officer with case management experience to assist with the development of policies and procedures and the training and mentoring of case management staff. This could be incorporated into the 'Status Resolution Officer' role that the Department is currently considering for offshore deployments.

Supporting Documents

Recommendation 1: The Review Team recommends that Transfield, together with MDA, consider the recommended changes and suggestions to the *Case Management in Offshore Processing Centres* document and provide feedback regarding the achievability of the recommendations.

Recommendations 6: The Review Team recommends that Transfield, together with MDA, consider the recommended changes and suggestions to the *Case Management in Offshore Processing Centres* and *Case Management Procedures Manual* documents and provide feedback regarding the achievability of the recommendations.

Recommendation 7: The Review Team recommends that Transfield consider including a section on arrival and induction processes within the *Case Management Procedures Manual* to ensure case managers develop a holistic understanding of processing of transferees, particularly if it informs case management processes at a later point.

Recommendation 8: The Review Team recommends that Transfield consider revising the 'Case Management Service Delivery Charter' to outline more explicitly that the role of the case manager is to manage a transferee's health and wellbeing and not advocate in relation to their refugee claims or the Refugee Status Determination (RSD) process.

Recommendation 10: The Review Team recommends that Transfield consider adding clarification to the Initial Needs Assessment (INA) procedure that the Transferee Needs Assessment conducted by Transfield Security could inform the INA rather than the same questions being asked of the transferees.

Recommendation 13: The Review Team recommends that Transfield review their policy and procedures document to ensure that the risk indicator tool is referenced appropriately as 'Case Management Risk Identification Tool,' as per the name of the document provided or reconsider the name of the document to appropriately fit the context i.e. vulnerability and behavioural risk identification.

Recommendation 14: The Review Team recommends that Transfield consider including a section on the use of the 'Case Management Risk Identification Tool' in the *Case Management Procedures Manual* to ensure a clear understanding of how this assessment is undertaken and more specifically, how it informs the level of case management intensity and engagement.

Recommendation 15: The Review Team recommends that the level of intensity and involvement table on the 'Case Management Risk Identification Tool' be updated to reflect the *Case Management in Offshore Processing Centres* policy document as it does not reflect the assessment relating to the level of case management involvement.

Recommendation 20: The Review Team recommends that Transfield consider including a section on service providers/teams relevant to case managers within the *Case Management Procedures Manual* including referrals and exchange of information processes.

Recommendation 28: The Review Team recommends that Transfield consider expanding the information within the *Case Management Procedures Manual* (in addition to 'Case Conferences') to include more detailed information regarding resources available to case managers, such as stakeholder meetings, which they can use to raise transferees of concern and to obtain information to inform IMP development and review.

Recommendation 31: The Review Team recommends that Transfield develop handover and discharge processes and incorporate these into the *Case Management Procedures Manual*.

Information Sharing

Recommendation 32: The Review Team recommends that a protocol of regular (daily) briefings to welfare staff be considered which covers the temperature of the centre and a summary of incidents to ensure staff are aware, and remain mindful of their safety and security during compounds walks.

Recommendation 33: The Review Team recommends that an agreed communication protocol is developed between Transfield and IHMS regarding the sharing of transferee personal medical information on Manus Island. This should be in addition to Recommendation 21 regarding a new consent process.

Recommendation 37: The Review Team recommends that a more structured communication and engagement strategy be implemented as a priority, to enable more efficient use of time and interpreter resources, whilst encouraging greater independence amongst the transferees.

Recommendation 38: The Review Team recommends that DIBP and Transfield on Manus Island invite PNG Immigration attend the Transferee Consultative Committee (TCC) meetings, or alternatively, set up another more appropriate forum for discussing the processing of claims and to provide general information about the broader assessment and resettlement process.

s. 22(1)(a)(ii)

s. 22(1)(a)(ii)

Training

Recommendation 9: The Review Team suggests that Transfield may wish to consider a separate case management induction or standard 'script' for case managers to ensure consistent messaging regarding the role of a case manager, which highlights professional boundaries and managing expectations. Transferees should also be provided with a fact sheet outlining the role of the case manager.

Recommendation 11: The Review Team recommends that Transfield reconsider the use of direct questioning around feelings of suicide or self-harm as this may trigger adverse reactions from the transferees and such questions should be left to IHMS mental health professionals. It would also be appropriate for this position to be discussed with Transfield Security.

Recommendation 12: The Review Team recommends that as part of training for all case managers, clarification is provided as to when it is appropriate to raise feelings or threats of self-harm as an incident given transferees may not be making a direct threat but rather expressing a feeling in the context of the environment and their individual circumstances.

Recommendation 19: The Review Team recommends that Transfield provide clear instructions regarding the use of the '*Case Manager Questions for Review of Individual Management Plan*,' ensuring that it is used only as a guide and that perhaps discussions with transferees at the time of review could be more informal rather than using structured questions. It is also appropriate to focus the review on need areas/changes in circumstances identified through other sources of information and following up on previously identified action items.

Recommendation 24: The Review Team recommends that Transfield, together with Transfield Security, consider onsite training for case managers and other welfare service staff on security awareness as well as the provision of intelligence gathering, focusing on interpreting information and how this should be conveyed to security personnel.

Recommendation 25: The Review Team recommends that Transfield consider enhancing their training on using interpreters which focuses on appropriate communication styles as well as considering the safety and security of interpreters. Transfield may wish to consider a local training program on using interpreters through their 'Toolbox Talks' which considers local safety and security

issues but more importantly, reminding case management staff of their obligations when working with interpreters.

Recommendation 26: The Review Team recommends that Transfield consider including a section on communication and engagement in their *Case Management Procedures Manual* to ensure an understanding of appropriate engagement strategies used by case managers and to develop a consistent approach within the case management team. This should include appropriate safety and security protocols that case managers should adopt and be conscious of when engaging with transferees.

Recommendation 27: The Review Team recommends that given the likelihood of external scrutiny that Transfield, as part of their training, ensure that all staff understand that the use of 'Boat IDs' solely when referring to transferees is not acceptable practice and that all written and verbal communication should also refer to the transferee by name. Transfield should encourage and monitor this practice amongst service providers at all sites.

Recommendation 34: The Review Team recommends that a 'Toolbox Talk' be developed that outlines the medical services available to transferees on Manus Island and the service delivery standards that IHMS works to. This may also include development of a standard 'tip sheet' on IHMS service provisions for case managers to ensure consistent understanding and messaging to transferees.

Recommendation 39: The Review Team recommends that Transfield and the Department consider brief training or an information sheet for case managers regarding the Refugee Status Determination (RSD) process to provide a consistent understanding of this process to assist in managing transferee expectations.

Role Classification

Recommendation 5: The Review Team recommends that between the Department and Transfield, clarification is provided regarding the appropriateness of the Refugee Status Determination Liaison Officer role and what it will entail. It is agreed that there needs to be a point of contact with the RSD team to ensure that information is able to flow to and from transferees, however it needs to be determined where this role would best sit. Considering that RSD decisions are being made by the host country it is unlikely that there will be any scope for escalation of cases by either case managers or DIBP officers.

Recommendation 22: The Review Team recommends that Transfield clarify and consider revising the information regarding referrals to IHMS to ensure it is clear that security teams primarily respond to medical emergencies or other incidents and that the standard referrals and escalations should be made through case management streams.

Additional Recommendations

s. 22(1)(a)(ii)

Recommendation 45: The Review Team recommends that the Department consider a further review of welfare services to be conducted within 3-6 months to evaluate progress following full implementation of systems and staffing model.

3.0 About Transfield Services Australia

3.1 Recruitment

Transfield have a dedicated human resources team allocated to recruitment for welfare positions on s 22(1)(a)(ii) Manus Island. Welfare roles have been designated as the highest priority and therefore the transition team is focused on sourcing and on-boarding people for those roles as soon as possible. In addition to filling all currently available roles, a talent pipeline is also being developed. Various employment types are available including Australian based support roles, Fly In Fly Out (FIFO) from Australia, FIFO from outside Australia and Local. Each position has a position description, statement of functional demand and a total fixed remuneration range.

All incumbent contractors were offered the opportunity to attend face-to-face briefings on island and lodge an expression of interest to work for Transfield. Initial 3-month employment contracts were offered to those who applied to ensure continuity whilst they go through the full Transfield selection process. Targeted recruitment has also occurred through internal approaches within Transfield, and staff referrals through their networks. Advertisements for new employees were run through the Transfield website and candidate database, LinkedIn, online advertising and notice boards, professional membership organisations and journals, vendor networks and relationships and sector specific recruitment companies.

The recruitment process consists of a qualifications review against the position description criteria (refer to Welfare Model and Staffing Structure for individual position requirements) and a subject matter expert review of qualifications and experience. This is followed by the first stage 15 minute structured telephone interview. If successful at this stage, candidates progress to an in-person interview either face-to-face or via Skype. This includes a 30-45 minute behavioural based interview, assessment against the position criteria, consultation with subject matter experts and follow up discussions where needed. A minimum of 2 reference checks are then conducted and must be with direct line managers or senior people within the candidates' current organisation. Prior to an offer being made, applications are reviewed and approved by management to ensure qualifications met and processes have been compliant.

Criminal History - all candidates must complete a statutory declaration regarding their criminal history. Australian based candidates must complete a national police check and all non-Australian based candidates are checked against the International Criminal Watch List.

Health Checks – all candidates must complete a statutory declaration at the beginning of the recruitment process. An online health assessment is also conducted along with a medical examination including drug and alcohol testing. Once a candidate is offered a position, they must undergo a full vaccination program, tailored to the location at which they will be working.

Resilience and Cultural Sensitivity – all candidates must undertake an online questionnaire to assess resilience related risk and protective factors associated with general wellbeing, trauma and cultural sensitivity. This is followed by a 45 minute structured clinical interview and report.

3.2 Training & Support

There are two components to the training of case management staff on s. 22(1)(a)(ii) Manus. Firstly, Transfield induction which is broken into three components, both prior to departure and on location and secondly, role specific training which is provided by Multicultural Development Australia (MDA) who are working in partnership with Transfield.

Transfield Induction

The Pre-departure Induction consists of the following modules: Welcome to Transfield; Safety and Security protocols for travel; Transfield Compliance – Code of Conduct, Equal Employment Opportunities, Probation, Fair Play model; Contract Compliance – media, mobile phones, RPC Code of Conduct, Privacy, Confidentiality. This is to be delivered online prior to departure from Australia.

The Health and Safety Induction consists of the following modules: Welcome to Transfield Health, Safety and Environment; Transfield Compliance – Mandatory safety rules, stop work authorization, incident management, risk management and global management system. This is currently delivered on island – development is currently underway to ensure those modules are delivered on-line prior to departure.

On Island Health and Safety/Security – RPC security and safety induction; RPC accommodation and living induction; RPC employee assistance induction; RPC policies and procedures; cultural induction – working with our local communities. This is conducted on island as a series of 'Toolbox Talks' and pre-start information sessions for staff.

Role Specific Induction

Stream Induction – Case management methodology; mental health induction; cultural competency induction; local worksite induction. This is currently conducted on island as an initial induction and follows with a series of toolbox sessions and pre-start information sessions for staff – the intention is that formal training will be completed with MDA in Brisbane prior to deployment or during the first 6 weeks of employment on the way to, or returning from the island.

Ongoing Training and Support

Transfield conducts ongoing training for all employees online as part of compliance with their internal HR strategies. There are currently discussions underway about content for an ongoing Professional Development program specifically aimed at case managers.

On island support is provided to all Transfield employees through their Workforce Wellbeing Safety Program which is delivered by PsyCare Assist. As part of this program, all employees participate in a daily kiosk check-in during which they provide a personal wellbeing rating and whether there are any safety critical issues they wish to raise. This data is assessed daily by Psycare and follow-up is available immediately if there are any concerns raised. There are also consultants on each site who conduct informal check-ins with all employees on a regular basis. 'Toolbox talks' complement the

support program by focusing on particular areas of concern or providing additional training if a need is identified. In addition there is an individual employee assistance program which employees may access at any time, both on and off island. Critical incident support, fitness for duty reviews (mandatory) and Manager Assist/Development are also available through the program. All Transfield staff must complete a Psycare debrief at the end of each two week stint on island.

Training Manuals

Transfield have formed a partnership with Multicultural Development Australia (MDA) to develop a case management model and the associated policy and procedural manuals. In addition to these manuals, MDA have also provided a series of Cultural Profiles which are provided to case managers to increase their knowledge and understanding of the different cohorts of transferees that they will be working with. The samples provided to the Review Team of these Cultural Profiles were of a high quality and gave an excellent snapshot of the predominant cohorts within the OPC. Further work may be required for some of the minority cohorts. The policy and procedural manuals are discussed in further detail below.

4.0 Transfield Case Management & Welfare Services Model

4.1 Introduction

Since the introduction of welfare services in addition to garrison services for single adult males (SAMs) under a new contract, Transfield was faced with a challenge to develop a case management model for transferees in OPC, something that it has not previously delivered under its suite of services offered at the OPC. Transfield contracted Multicultural Development Australia (MDA) to assist in the development of a best practice model based on their experience with the case management of clients in a community setting. MDA, a non-government organisation, specialises in settlement services and the active promotion of multiculturalism. MDA is currently contracted by the Department to provide settlement services for both onshore protection and humanitarian refugees. As such, they have experience in providing case management to a diverse range of clients and assisted Transfield to develop a model that would be suited to the management of transferees in an offshore setting, under the current Government policy.

From discussions with MDA, it was identified that their primary focus is assisting in the settlement of refugees from a range of cultural backgrounds, and providing support in accessing appropriate services for those with complex medical needs – both physical and mental health, and for survivors of torture and trauma. This experience makes them well-placed to tailor a case management and support model suited to the particular needs of a variety of cohorts. MDA reported that they currently employ over 270 cultural liaison officers, which are used to assist in ensuring case management plans are tailored to the individual needs of their clients.

4.1 Policy Document: Case Management in Offshore Processing Centres

Together with Transfield, MDA developed an over-arching policy model to assist in informing a training package suited to case management staff as well as to assist Transfield in the development

of operational procedures to support staff on the ground and to provide a base for case management services at the OPCs. It should be noted that the model has been developed to focus on the case management of single adult males (SAMs). s. 22(1)(a)(ii)

The policy document provides the basic principles of the case management model which considers the demographic and the environment of the OPCs. It is evident however, that MDA has based that on what is delivered in a community setting and adjusted to consider the circumstances and the environment that comes with OPCs. While a good base, the Review Team has made some recommendations to MDA and Transfield regarding the structure of the document and important points which need to be highlighted for case managers working in an offshore environment. Some of these will be discussed throughout the review paper, particularly around Transfield's case management procedures.

Recommendation 1: The Review Team recommends that Transfield, together with MDA, consider the recommended changes and suggestions to the *Case Management in Offshore Processing Centres* document and provide feedback regarding the achievability of the recommendations.

4.2 Case Management Definition & Underpinning Values

The Transfield case management model instructs that the purpose of the 'case management and meaningful activities model is to ensure the well-being of transferees so that they can remain engaged with their status resolution process. These services form part of a holistic, integrated approach to maintaining the wellbeing of the centre and its people,' (*Case Management in Offshore Processing Centres*, Transfield Welfare Services, 2014). In discussing this definition with Transfield together with MDA, the Review Team recommended that there be a clear definition and distinction that the Transfield case managers are not status resolution officers and should not advocate or engage in discussions with transferees regarding their immigration pathway. Transfield case managers are solely responsible for managing the welfare of transferees to ensure they remain engaged with services and support to maintain their health and wellbeing while at the OPC.

Recommendation 2: Transfield to ensure that a clear definition of a case manager under the welfare service model is provided to ensure that they are aware that they do not advocate or engage in status resolution discussions with transferees and ensure their training program reflects the same.

The core values of the case management model is focused on the appropriate treatment of transferees, upholding their dignity and treating them with respect, irrespective of nationality, ethnicity, gender, religion, age, sexual preference, ability, social and economic status, beliefs or medical status. It ensures that case management is provided on an individual basis suited to the individual needs of the transferees and their circumstances as well as an involved or self-agency approach, whereby transferees also contributed to their individual management. It is expected that the case management focus in the offshore processing environment will be to:

- Assist transferees to cope with the environment and engage meaningfully
- Adopt a holistic approach

- Consider the emotional, psychological, social and cultural foundations of transferees
- Intensive early intervention and accurate development of case management plans and needs assessments to prevent problems occurring later when they become more complex
- Maintaining privacy of transferees at all times
- Understanding the conditions the transferees are residing in will enable case managers to understand the transferee's state of mind and help ensure that case plans effect the needs of the transferees.

(*Case Management in Offshore Processing Centres*, Transfield, 2014)

The Review Team recognised some inconsistencies in the terminology used throughout the policy documents including the use of the term 'clients' rather than 'transferees' however were provided with an updated versions which corrected this. However, some references to 'detention' rather than 'Offshore Processing Centres' continue to be used and therefore, for consistency and to ensure correct use of terminology, the Review Team highlighted this to Transfield and MDA.

Recommendation 3: Transfield to ensure that the use of the term 'detention' is removed from all policy and procedure documents and ensure their staff are aware of the correct policy terms, being 'Offshore Regional Processing' when referenced within Australia and 'Regional Processing Centre' when referenced from s. 22(1)(a)(ii) **Manus Island.**

4.3 Core Features

The *Case Management in Offshore Processing Centres* policy document sets out that the core features to the Transfield case management approach includes:

- Assessment of individual needs
- Mobilisation of resources
- The formation of relationships between case manager and transferee
- The use of the case manager as a model of pro-social behaviour; and
- Active intervention in the transferee's daily life to structure a mutually beneficial/conducive environment.

The case management model encourages successful relationship building with the transferee by the case manager, being the primary contact point for transferees in the OPC environment. This is done by providing emotional support and showing empathy to the transferee's circumstances and appreciation of the environment however also maintaining professional boundaries and managing expectations. The Review Team did discuss with both Transfield and MDA the importance of highlighting professional boundaries and managing expectations of transferees, particularly around the separation of their role of managing welfare from the Refugee Status Determination (RSD) process and the refugee claims of the transferees. Whilst professional boundaries are highlighted in the policy document, the Review Team considered that clearer definitions regarding the role of case managers was needed to ensure that professional boundaries are clear, particularly when discussing emotional support and showing empathy.

In addition, the case management model directly references that the role of the case manager is to 'advocate' for a transferee and while it does not mention advocating an outcome to their immigration case, the Review Team felt that this could add confusion and suggested that such references be removed or at the very least, clarified. In discussing this with MDA, it is recognised that case managers will advocate for transferees in relation to health and welfare however the term can easily be misinterpreted within the context of an OPC environment. The Review Team has requested that the policy documents make it clear that the role of a case manager is not to advocate in relation to the transferee's refugee claims or immigration pathway.

Recommendation 4: The Review Team recommends that Transfield reconsider the use of the term 'advocate' in their training and policy/procedures documents given the potential misinterpretation in the context of working with transferees.

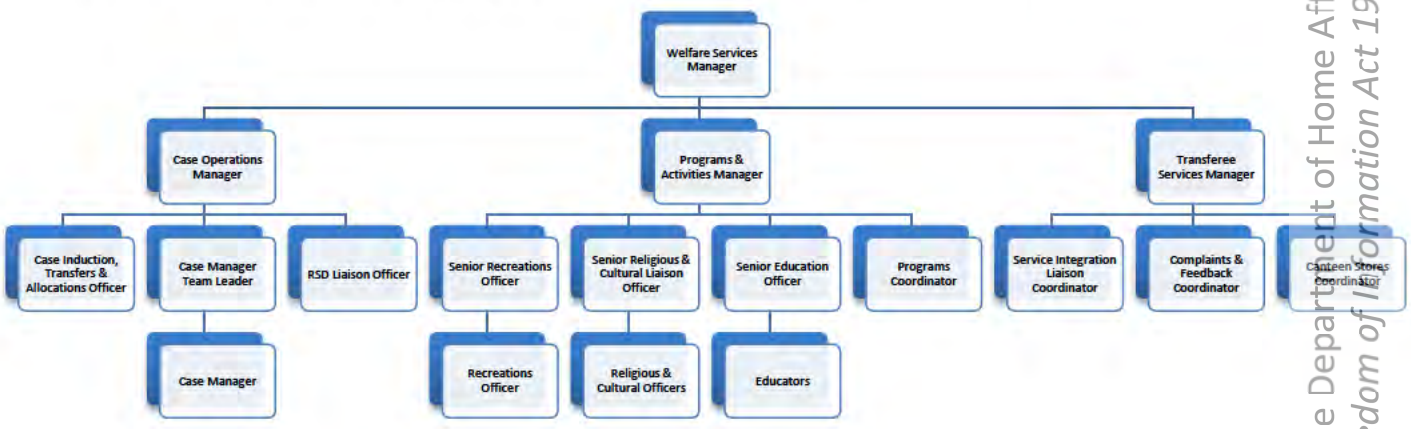
Case managers are required to complete an Initial Needs Assessment (INA) to inform the development of an Individual Management Plan (IMP) and the assessments need to ascertain:

- Needs
- Vulnerabilities
- Strengths.

The core focus of the needs assessment and IMP development is to ensure that the case manager forms a holistic view of the transferee's individual needs and an appropriate management plan is developed which caters for these individual needs and ensures appropriate services are in place to support any vulnerabilities.

4.4 Welfare Model & Staffing Structure

Welfare Services are led by a Welfare Services Manager, overseeing three branches of welfare services. The following flow chart indicates the intended welfare services staffing structure at both OPCs. This is followed by details of some of the key roles employed under this model which the Review Team would like to highlight for the purpose of this review.



4.4.1 Case Operations

Case operations are responsible for the management and coordination of case management and related services for single adult males (SAMs) at the OPCs. The case operations team are responsible for the induction and allocation of all new arrivals to the case management team.

Case Managers

Case managers and their team leaders sit under this team and will be responsible for conducting initial interviews and development of Individual Management Plans (IMP) based on the Initial Needs Assessment (INA) which will identify transferees needs based on their personal circumstances and will generate referrals to service providers. Case managers will be the primary point of contact in relation to transferees and their welfare needs and will be responsible for regularly review of IMP to ensure they take into consideration their changing needs.

Refugee Status Determination (RSD) Liaison Officer

The case operations team also intend to appoint a Refugee Status Determination (RSD) Liaison Officer, which, according to the position description, will be responsible for the coordination of the RSD process and liaison with relevant stakeholders for the purpose of facilitation of RSD interviews for transferees. It is expected that this position will also be responsible for keeping transferees up to date with matters relating to their RSD. From discussions with both Transfield and local DIBP staff, it is unclear how this role will be developed within the OPCs given the host Governments are responsible for the RSD process. Currently, in both Manus s. 22(1)(a)(ii), there are DIBP officers working with the local RSD teams, in both mentoring and interviewing capacities. Requests for transferees to attend RSD interviews are provided to Transfield Security, and escort of the transferees to the interview rooms is arranged as part of this process. Further clarification is needed around how Transfield will perform this role and what 'liaison and facilitation' of the RSD process actually entails. It is unclear how Transfield will be involved in the RSD process and whether this is appropriate at all. This role may sit better with a DIBP officer as opposed to within the Transfield case management team.

Recommendation 5: The Review Team recommends that between the Department and Transfield, clarification is provided regarding the appropriateness of the RSD Liaison Officer role and what it will entail. It is agreed that there needs to be a point of contact with the RSD team to ensure that information is able to flow to and from transferees, however it needs to be determined where this role would best sit. Considering that RSD decisions are being made by the host country it is unlikely that there will be any scope for escalation of cases by either case managers or DIBP officers.

4.4.2 Programs and Activities

The Programs and Activities team is responsible for the management and effective delivery of programs and activity services which recognise the demographics and cultural needs of

the transferees at the OPC. This includes recreation, education and cultural and religious activities which are designed to maintain the health and wellbeing of transferees whilst they await the completion of the RSD process, or are returned voluntarily or involuntarily to their home country. Programs and activities will inform the IMP developed by the case managers based on the INA as well as direct input from the transferees' themselves.

It is the Review Team understands that as part of this function, the Programs and Activities team is responsible for analysis of data related to attendance numbers, feedback from staff and transferees and availability of resources to ensure programs and activities remain relevant and suited to the needs and wellbeing of the transferees.

s. 22(1)(a)(ii)

Religious & Cultural Liaison Officers (RCLO)

As a part of its programs and activities service model, Transfield employs Religious & Cultural Liaison Officers (RCLOs) who are responsible for providing a range of cultural and religious activities based on the demographic, gender and cultural needs of the transferees at the OPCs. They also provide assistance and advice to staff, including case managers and Security regarding religious and cultural matters, including key events in addition to general engagement advice with various cultures. RCLOs are usually from a similar cultural background to one or more cohorts within the centre, have qualifications and/or experience with working with a diverse group of people, and often have language skills which allow for greater interaction with the transferees without the need for an interpreter. The position description does not specify a need for language skills, rather it focuses on RCLOs having cultural competence and experience working with diverse backgrounds both culturally, religiously and linguistically.

RCLOs are present daily in transferee compounds and actively assist transferees to access specific services as well as to assist in the development of basic understanding of living in an OPC. This includes assisting transferees to make requests and complaints if they have difficulty understanding the process or perhaps, due to illiteracy or specific medical issues, cannot complete requests and complaints themselves.

4.4.3 Transferee Services

The Transferee Services team is responsible for the 'customer service' element of the welfare services at the OPCs, delivering services such as the library, canteen, stores and complaints and feedback services to transferees. The Transferee Services team has a strong link to both the case operations and programs and activities team as these teams rely, particularly on the feedback and complaints process to inform reviews of their services and ensure they remain current to the changing wellbeing needs of the transferees.

Complaints and Feedback Coordinator

The Complaints and Feedback Coordinator is responsible for ensuring that transferees have access to a process where they are able to provide feedback and complaints in relation to

services affecting them in the OPCs. They are the central coordination point of all feedback and complaints and are responsible for allocation of these to relevant areas and service providers. Subsequently, they will ensure that complaints are actioned in a timely matter based on agreed service standards, taking into consideration the complaints processes of the different service providers.

It is the Review Team's understanding that the Complaints and Feedback Coordinator will also conduct analysis of trends, responses, and timeframes to identify ongoing issues with services and possible improvements that can be implemented. This role will work closely with the Service Integration Liaison Coordinator, to ensure that corrective actions are implemented in a timely manner. There is an expectation from both Transfield and the Department that data entry and storage of this data will be of a high standard given the potential for external scrutiny if complaints are not resolved in a timely manner and a high number a of complaints are received in relation to a particular area.

5.0 Case Management Procedures

5.1 Case Management Procedures Manual

Following the development of the *Case Management in Offshore Processing Centres* model, MDA have produced a *Case Management Procedures Manual* to be used as a training and information guide for case management staff on the ground. It is based on the overarching case management model developed in conjunction with MDA and sets out the case management service provisions and key tasks of a case manager together with links to other services to assist in the development and review of appropriate management plans for transferees.

The Review Team spent considerable time reviewing these processes, together with discussions with local teams in order to determine how they were implemented in practice. A considerable amount of feedback was provided in relation to the format of these procedures as well as other suggested areas to consider, to highlight that a holistic view of the OPC operations should be included, particularly around the provision of case management services and the link to other service providers.

Recommendations 6: The Review Team recommends that Transfield, together with MDA, consider the recommended changes and suggestions to the *Case Management in Offshore Processing Centres* and *Case Management Procedures Manual* documents and provide feedback regarding the achievability of the recommendations.

5.2 Arrival & Induction

Whilst the procedures document does not explicitly outline the arrival and induction procedures for new arrivals to the OPCs, it is the Review Team's understanding that upon arrival, Transfield Security together with IHMS are responsible for managing initial arrival processing. This includes an induction by Transfield Security in relation to living at an OPC as well as completing an INA to ensure basic needs are identified on arrival. IHMS will undertake a basic health induction (to identify

immediate health needs) as well as a general group induction to inform transferees of medical services and how these are accessed.

Recommendation 7: The Review Team recommends that Transfield consider including a section of arrival and induction processes within the *Case Management Procedures Manual* to ensure Case Managers develop a holistic understanding of processing of transferees, particularly if it informs case management processes at a later point.

Following this, case management is required to complete an Initial Needs Assessment (INA) which is explained further below. As part of the INA interview, or at least at the first meeting with the transferee, case managers are expected to clarify their role and more specifically 'the scope and authority of the case manager,' as stated in the *Case Management in Offshore Processing Centres* model. The *Case Management Procedures Manual* sets out the 'Case Management Service Delivery Charter,' which provides the expected service standards that will be delivered by case managers. Throughout this and the procedures document, what it does not highlight is the importance of setting professional boundaries and managing transferee expectations and therefore, providing a clear definition of the role of a case manager **(refer to Recommendation 2).**

Recommendation 8: The Review Team recommends that Transfield consider revising the 'Case Management Service Delivery Charter' to outline more explicitly that the role of the case manager is to manage a transferee's health and wellbeing and not advocate in relation to their refugee claims or the RSD process.

Recommendation 9: The Review Team suggests that Transfield may wish to consider a separate case management induction or standard 'script' for case managers to ensure consistent messaging regarding the role of a case manager, which highlights professional boundaries and managing expectations. Transferees should also be provided with a fact sheet outlining the role of the case manager.

5.3 Initial Needs Assessment (INA)

Following the initial arrival induction and Transferee Needs Assessment conducted by Transfield Security, case managers are required to complete an Initial Needs Assessment (INA) within 3 days. Based on feedback from local Transfield case management teams, it appears that the INA is a new process and there is no instruction that the Transferee Needs Assessment informs the INA. The Review Team considers that given aspects of the INA is already covered in the Transferee Needs Assessment, it may be appropriate to pre-populate the information into the INA to save the transferees being asked the same questions again.

Recommendation 10: The Review Team recommends that Transfield consider adding clarification to the INA procedure that the Transferee Needs Assessment conducted by Transfield Security could inform the INA rather than the same questions being asked of the transferees.

The following table depicts the areas covered by the INA:

1.0 – Self Care and Basic Needs	1.1 – Self Care

	1.2 – Basic Needs
	1.3 – Living Arrangements
	1.4 – Disability
2.0 – Emotional Needs	2.1 – Emotional Needs
3.0 – Cultural and Religious Needs	3.1 – Community Links (within the OPC)
	3.2 – Religious Needs
4.0 – Social Participation	4.1 – Language (including English skills)
	4.2 – Education
	4.3 – Skills Audit
	4.4 – Meaningful Activities
5.0 – Health and Mental Health	5.1 – Health and Mental Health Needs
	5.2 – Health Orientation Check
6.0 – Vulnerability and Behavioural Risks (refer to Case Management Risk Identification Tool)	6.1 – Family Needs
	6.2 – Vulnerabilities
7.0 – Other	*Any other relevant information*

While most questions associated with each section seem appropriate for the purpose of assessing immediate need, the Review Team holds some concerns with the use of questioning under **6.0 – Vulnerability and Behavioural Risks**, namely, questions relating to whether the transferee has feelings of harming themselves or others. As part of the health induction on arrival, IHMS should cover this assessment based on initial observations and presentation of the transferee, together with any self-disclosures at the time. Past experience indicates that questions such as these from both medical and non-medical personnel to clients in similar environments can trigger frustration and anger given they may likely be asked this on more than one occasion. It is also understood that Transfield Security cover this as part of its initial assessment. Case managers may experience a high rate of transferees disclosing feelings of self-harm (whether truthful or not) which may possibly result in a high number of referrals to IHMS or generation of incident reports (depending on how and what was disclosed). The Review Team considers that indicators around possible risk of harm to self or others are better identified through the transferee's presentation (i.e. distress, withdrawal etc.), the transferee's own self-disclosure or through disclosure of past traumatic events which may indicate that they are at risk.

Recommendation 11: The Review Team recommends that Transfield reconsider the use of direct questioning around feelings of suicide or self-harm as this may trigger adverse reactions from the

transferees. Such questions should be left to IHMS mental health professionals. It would also be appropriate for this position to be discussed with Transfield Security.

Recommendation 12: The Review Team recommends that as part of the training for all welfare staff, clarification is provided as to when it is appropriate to raise feelings or threats of self-harm as an incident given transferees may not be making a direct threat but rather expressing a feeling in the context of the environment and their individual circumstances.

Case Management Risk Identification Tool

The *Case Management in Offshore Processing Centres* policy document references the use of a 'Risk Indictor Tool' called the *'Case Management Risk Identification Tool'* which a case manager **must** use to assess risk factors of the transferee to inform the IMP. Firstly, it is evident that the name of this tool is used inconsistently throughout both the *Case Management in Offshore Processing Centres* and *Case Management Procedures Manual* which include 'Vulnerability and Risk Identification Tool' and 'Assessment of Vulnerability and Behavioural Risk Tool Template' while the document itself is called, as stated above, the 'Case Management Risk Identification Tool.'

Recommendation 13: The Review Team recommends that Transfield review their policy and procedures document to ensure that the risk indicator tool is referenced appropriately as 'Case Management Risk Identification Tool,' as per the name of the document provided or reconsider the name of the document to appropriately fit the context i.e. vulnerability and behavioural risk identification.

While the policy and procedures document does reference that case managers should use this tool to assist in the identification of risks and subsequently, the level of intensity and frequency of case management involvement, what they lack is explicit information about how it is used by case managers. More specifically, how the identification of vulnerabilities and behavioural risks informs the level of case management intensity and involvement (or engagement). The 'Behaviour Risk Indictor' sets out appropriate risk identifiers and instructs case managers to set the level of risk appropriate to the circumstances of the transferee (based on the INA). The vulnerability indicator consists of a series of questions, however it is unclear how the case manager would draw conclusions regarding the level of vulnerability and how this would translate into the level of case management intensity and engagement.

Recommendation 14: The Review Team recommends that Transfield consider including a section on the use of the 'Case Management Risk Identification Tool' in the *Case Management Procedures Manual* to ensure a clear understanding of how this assessment is undertaken and more specifically, how it informs the level of case management intensity and engagement.

Recommendation 15: The Review Team recommends that the level of intensity and involvement table on the 'Case Management Risk Identification Tool' be updated to reflect the *Case Management in Offshore Processing Centres* policy document as it does not reflect the assessment relating to the level of case management involvement.

Transfield may also benefit from considering the impact on the workload of case managers who may be managing a high number high intensity/high need transferees while other case managers may have a caseload of transferees with low needs. This could lead to inequality in the workloads of case

managers and also affect the level of attention provided to high-need transferees if a large number are managed by the same case manager.

Recommendation 16: The Review Team recommends that Transfield consider an appropriate caseload allocation model which considers the level of case management intensity and engagement of transferees and ensures an equal distribution of complex workloads amongst case managers. The *Case Management Risk Identification Tool* could be used to assist in identifying case complexities and therefore, inform the allocations model.

5.4 Individual Management Plan (IMP) & Review

The completion of the INA process will result in the development of a formal IMP based on the identified needs and subsequent action items. The *Case Management in Offshore Processing Centres* document indicates that that the IMP should be reviewed every 28 days (or 4 weeks), however, each individual action item (or case plan item) may have its own completion timeframe, depending on the item i.e. referral to English classes within 7 days. It is the responsibility of the case manager to ensure that each action item is completed by the due date or otherwise review the action item if it is not achievable by the original deadline.

The Review Team discovered a discrepancy between the *Case Management in Offshore Processing Centres* and *Case Management Procedures Manual* documents in relation to the timeframe in which the IMP should be reviewed. As indicated above, the *Case Management in Offshore Processing Centres* provides an indication that IMPs should be reviewed every 28 days however the *Case Management Procedures Manual* instructs that the IMP should be reviewed every 2 weeks. Discussing this with local Case Management staff s. 22(1)(a)(ii) Manus Island, it appears that the 2 week review period was suggested to coincide with the Case Manager change over schedule, meaning that each Case Manager, during their 2 week deployment, will undertake a review of the IMP. The *Regional Processing Guidelines*, issued by the Department, indicate that a case manager IMP review should be undertaken at the 2 week mark, following which, a multi-stakeholders meeting (not involving the transferee), should be undertaken at the 4 week mark, noting input from other service providers working with the Transferee.

Recommendation 17: The Review Team recommends that Transfield, together with the Department, clarify the position around timeframes for review of the IMP and expectations in relation to review mechanisms.

In discussing with Transfield Welfare Services the position of a case manager review, followed by a multi-disciplinary review, the Review Team suggested the possible use of the Complex Behaviour Meeting (CBM) (discussed below) which is managed by Transfield Security with a focus on developing strategies with other service providers in relation to the management of transferees with behavioural concerns. It appears however, that this meeting is also used by stakeholders to raise transferees of concern, not necessarily related to behaviour, which from the perspective of the Review Team, is considered a good use of this meeting. Recommendations regarding the structure of this meeting are made later in this report. It was suggested that Transfield may wish to explore the use of this meeting as an IMP review mechanism to allow for appropriate input by service providers and subsequently ensure that the IMP captures the changing needs (if applicable) of the

transferees. This may involve Transfield providing a list of transferees who are due for an IMP review and requesting service providers to provide updates to inform the review.

Recommendation 18: The Review Team recommends that following clarification of the position around timeframes, and the mechanism for IMP reviews, that Transfield consider the use of the CBM as a review mechanism to allow for service provider input to inform the review.

The review of the overall IMP by the case manager occurs to ensure that the transferee needs and actions items remain current and appropriate, and to factor in changes in the transferee's needs i.e. changes in medical circumstances. To assist case managers in completing the IMP review, the *Case Management Procedures Manual* provides 'Case Manager Questions for Review of Individual Management Plan' which sets out a series of suggested questions, similar to those in the INA. These questions revisit each of the areas of the IMP (refer to table under INA section) and are used to ensure that actions remain appropriate and any changes in the transferee's circumstances are considered. The Review Team considers that while the use of this document can assist case managers in ensuring that questions are focused on reviewing the elements of the IMP, using this form of questioning every two weeks may aggravate the transferee and therefore, this should be approached carefully and more specifically, target needs identified through other sources of information i.e. Transfield Security, IHMS etc.

Recommendation 19: The Review Team recommends that Transfield provide clear instructions regarding the use of the *'Case Manager Questions for Review of Individual Management Plan,'* ensuring that it is used only as a guide and that perhaps discussions with transferees at the time of review could be more informal rather than using structured questions. It is also appropriate to focus the review on identified need areas/changes in circumstances identified through other sources of information and following up on previously identified action items.

5.5 Referrals to Service Providers

Within the *Case Management Procedures Manual*, Transfield does reference the need for case managers to make referrals to, and engage with service providers, mainly referencing IHMS and Save the Children. There is limited information within the procedures document on who the service providers are, what they do, and when case managers may need to engage with them, in addition to other areas within Transfield (and contractors) i.e. Programs and Activities, Transferee Services (requests and complaints), Transfield Security (for the purpose of intelligence sharing, managing behavioural transferees) etc.

Recommendation 20: The Review Team recommends that Transfield consider including a section on service providers/teams relevant to case managers within the *Case Management Procedures Manual* including referrals and exchange of information processes.

IHMS

Transfield will primarily work with IHMS in relation to the management and support of transferees at OPCs. Transfield relies on IHMS to inform the INA and subsequent development of an IMP and ensure basic needs from a medical perspective i.e. allergies, accommodation needs, management of long-term medical needs etc. are captured. Whilst the procedures document does highlight the

need for IHMS input, it is not clear how this will occur and whether there is any specific protocol for the sharing of such information. In discussing this with both Transfield and IHMS on s. 22(1)(a)(ii) Manus Island, it appears that these discussions have not yet been had or at least not to the extent required in order to formalise a process.

IHMS have privacy concerns regarding the level of information required as the consent form signed by transferees on Christmas Island, prior to transfer to an OPC, limits information sharing to the exchange of information between IHMS, the Commonwealth of Australia and other non-IHMS medical professionals. This consent form does not extend to information sharing with Transfield case managers. Recent changes to privacy laws in Australia have also heightened IHMS concerns regarding information sharing without explicit consent and the Review Team understands that this issue has also been raised with the Department (OPC Service Delivery) by Transfield.

Recommendation 21: The Review Team recommends that Transfield, together with the Department, consider a new consent process on arrival at the OPCs to cover the exchange of basic medical information between service providers to assist in the appropriate management of transferee needs.

From a Transfield perspective it is acknowledged that case managers do not require detailed medical information, however Transfield states that certain information which may affect transferee placement and management is needed to ensure a holistic understanding of transferee needs are formed. This includes, but is not limited to:

- Allergy information and other specific dietary requirements i.e. diabetes sufferers
- Accommodation and mobility needs i.e. transferees with a particular disability who may for example, need specific bedding or cannot be accommodated on a top floor.
- Specific medical issues that prevent participation in particular programs and activities i.e. transferees who cannot participate in high-intensity sports. Perhaps not specific details of the medical issue however at the very least, details from IHMS on activities that are not appropriate due to 'a medical condition.'
- Transferees with long-term medical issues that require on-going treatment or medication. case managers will benefit from this information as they can monitor changes in the transferee's presentation and subsequently notify IHMS as well as encourage participation in treatment.
- Details of referrals to torture and trauma (or other specialised) counsellors to ensure that changes in the transferee's presentation are reported and to encourage engagement. It should be noted that torture and trauma counselling is provided by Survivors of Torture and Trauma Rehabilitation and Assistant (STTARS) at both OPCs.

The Review Team developed a fact sheet for case managers on Manus Island to clarify the types of medical information they could request from IHMS based on the above s. 22(1)(a)(ii) This was endorsed by the Health Services Manager from IHMS and will be distributed to all relevant staff.

The *Case Management Procedures Manual* indicates that referrals or escalations of medical issues should be made through case manager team leaders or 'Security.' It is understood that IHMS have

requested that escalations occur through one point of contact rather than allowing case managers to escalate concerns independently, to prevent an overload of referrals and to ensure appropriate monitoring of escalation requests. The Review Team queries the option to escalate medical referrals to 'Security' rather than through case management channels except in instances of responding to particular incidents, especially medical emergencies. Other than responding to incidents, it is considered outside the scope of the role of security teams to escalate medical referrals.

Recommendation 22: The Review Team recommends that Transfield clarify and consider revising the information regarding referrals to IHMS to ensure it is clear that security teams primarily respond to medical emergencies or other incidents and that the standard referrals and escalations should be made through case management streams.

Overall, in considering how the exchange of information between Transfield and IHMS for the purpose of informing IMP development and review should occur, the Review Team recognises that each OPC may adopt different processes based on local factors and limitations, however, it appears limited discussions regarding this have been had so far. It is important that between Transfield and IHMS, an overarching protocol relating to both OPCs be considered and documented to ensure establishment of consistent processes in both locations and to ensure case managers have a good understanding of this. It is recognised that the development of a local consent process (**refer to Recommendation 21**) would assist with this process given concerns IHMS hold regarding the exchange of medical information.

Recommendation 23: The Review Team recommends that Transfield undertake further discussion with IHMS regarding the establishment of a protocol for the sharing of information to assist in informing the management of transferees at OPCs, particular on arrival to an OPC. This includes the establishment of an escalation process for follow up of medical referrals.

s. 22(1)(a)(ii)

[redacted]

Transfield Security (Operated by Wilson Security)

As the title suggests, Transfield security (operated by Wilson Security) is responsible for overall security of the OPCs including the intelligence gathering, analysis and forecasting as well as responsibility of overall risk assessment of the centres (low, medium or high risk) based on any internal or external risks or tensions within the OPCs. Transfield Security also provides critical incident response (i.e. riots, major disturbances) which is managed by the Emergency Response Team (ERT). The Review Team noted that case managers and other welfare services staff will rely on Transfield Security to provide safety and security during transferee engagement including escorts

when the risk level within the centre is elevated. More importantly, provision for information sharing between welfare and security exist to ensure a) welfare staff are aware of particular intelligence information about a compound to ensure they are mindful of any issues for the purpose of their own safety and security and b) intelligence information obtained by staff who engage with transferees to assist with informing risks assessment and trends of behaviour that may highlight the presence of particular issues.

Transfield Security also provide semi-welfare services in the form of welfare officers known as 'Whiskeys' who are responsible for general compound presence and who engage with transferee's for the purpose of general welfare monitoring and intelligence gathering. Whiskey Officers also play a key role in the management of Behavioural Management Plans (discussed below), as they work with transferees to encourage positive engagement and contribute to the formation of strategies used to manage particular behavioural concerns. Transfield Security use Cultural Officers, similar to the Cultural and Religious Liaison Officers within the welfare services team, to provide cultural awareness within the compounds and to assist in the management of transferees together with the welfare officers.

It is important that case management staff are aware of the protocol of intelligence collection and procedures for sharing such information with security personnel. This reinforces the recommendation on updating procedure documents to ensure case managers are aware of service providers they will work with and the importance of them for their role (as well as the benefit to other service providers). Additionally, due to the importance of security personnel and the need for case managers to be mindful of their security, Transfield should consider site training, delivered by Transfield Security on security awareness as well as intelligence collecting.

Recommendation 24: The Review Team recommends that Transfield, together with Transfield Security, consider onsite training for case managers and other welfare service staff on security awareness as well as the provision of intelligence gathering, focusing on interpreting information and how this should be conveyed to security personnel.

As part of their security role, Transfield Security manages the behavioural management program, which includes the consideration of Behavioural Management Plans (BMP) for transferees with behavioural issues and/or frequent incident involvement. Transfield Security works closely with case managers to assist in informing the IMP to ensure the IMP factors in strategies for the management of behavioural issues and to promote positive behavioural changes in an attempt to prevent reaching the need for BMP implementation. Transfield Security also manages the Complex Behaviour Meeting (CBM), a multi-stakeholder meeting which focuses on the management of transferees with behavioural issues as well as other vulnerable transferees. This meeting is discussed further below.

Training and Resources

Transfield Security provides the following training and resources to their welfare and cultural officers:

- How to identify self-harm related behaviour
- Dealing with violence

- Dealing with asylum seekers
- Cultural Awareness
- Negotiation Skills
- Rapport Building

5.6 Communication and Engagement

Although the *Case Management Procedures Manual* does not specifically discuss the types of communication and engagement that case managers should employ when working with transferees, the Review Team understands that training is provided in interviewing techniques as well as working with interpreters, the latter of which is briefly discussed in the policy model and procedures manual. In relation to working with interpreters, the Review Team worked with Transfield at both sites to provide some brief training based on onshore experience as well as a tip sheet of 'do's and don'ts' to ensure a clear understanding of using interpreters. The Review Team has provided some feedback in relation to working with interpreters, particularly around the provision of talking to the transferee, not the interpreter as well as safety and security protocols such as not leaving the interpreter alone and not taking them into transferee accommodation.

Recommendation 25: The Review Team recommends that Transfield consider enhancing their training on using interpreters which focuses on appropriate communication styles as well as considering the safety and security of interpreters. Transfield may wish to consider a local training program on using interpreters through their 'Toolbox Talks' which considers local safety and security issues but more importantly, reminding welfare service staff of their obligations when working with interpreters.

From observations of both sites, it appears that engagement by case management staff was managed more 'informally' through general compound walks or locating the transferee themselves when they need to conduct an interview or discuss a particular issue (impacted heavily by minimal interpreter availability). The Review Team discussed the employment of more formal engagement processes to ensure a consistent approach in regards to transferee engagement, which includes, but are not limited to:

- Structured compound walks with designated times
- Consideration of a case management 'Shopfront'
- Consideration of a formal appointment booking process including the use of appointment slips (for a number of services) which encourages 'self-agency' by the transferee.

Recommendation 26: The Review Team recommends that Transfield consider including a section on communication and engagement in their *Case Management Procedures Manual* to ensure an understanding of appropriate engagement strategies used by case managers and to develop a consistent approach within the case management team. This should include appropriate safety and security protocols that case managers should adopt and be conscious of when engaging with transferees.

In relation to appropriate communication with transferees, the Review Team noticed that at both OPCs, the use of 'boat IDs' by a number of service providers was common practice, rather than the

use of transferee names. The Review Team provided feedback to Transfield at both sites that this practice should cease and that transferees should be referred to by their names only in face-to-face communication. It is recognised however, that the use of the 'boat ID' is an important identifier, particularly when many transferees have very similar names, or discussing a cohort from the same boat. At times it may be appropriate to use the 'boat ID', however this should always be accompanied by the name of the transferee both in written and verbal communication, including when communicating over the radio.

Recommendation 27: The Review Team recommends that given the likelihood of external scrutiny that Transfield, as part of their training, ensure that all staff understand that the use of 'Boat IDs' solely when referring to transferees is not acceptable practice and that all written and verbal communication should also refer to the transferee by name. Transfield should encourage and monitor this practice amongst service providers at all sites.

5.7 Stakeholder Meetings & Resources

From observing case management operations on both OPCs, the Review Team recognised that case managers have available, and participate in, a number of multi-stakeholder meetings designed to discuss particular transferees of concern. Whist some are referenced in the *Case Management Procedures Manual*, information on the suite of resources available to case managers, such as stakeholder meetings used to obtain information or raise transferee's of concern is not thoroughly available. Some of these are discussed below.

Recommendation 28: The Review Team recommends that Transfield consider expanding the information within the *Case Management Procedures Manual* (in addition to 'Case Conferences') to include more detailed information regarding resources available to case managers, such as stakeholder meetings, which they can use to raise transferees of concern and to obtain information to inform IMP development and review.

Psychological Support Program (PSP) & Supportive Engagement & Monitoring (SME)

PSP/SME are daily meetings chaired by IHMS and focus on discussing transferees who are at risk of suicide or self-harm, or general concerns which may lead to these risks. Official placement of a transferee on PSP/SME may follow an incident including threats, actual self-harm or a deterioration of a transferee's mental health that may indicate that they are at risk. This may result in appropriate monitoring arrangements (by Transfield Security) depending on the level of risk.

In addition, it appears at both OPCs, service providers have an opportunity to raise 'transferees of concern' who may not yet be at the stage of formal PSP/SME monitoring, however due to concerns over their presentation or involvement in an incident, are worth flagging with other services providers to monitor and for appropriate feedback. Whist this is important, it is the understanding of the Review Team that the primary focus of this is to raise transferees who have the potential to deteriorate and should be monitored by all service providers. More specific issues and the discussion of appropriate management strategies for transferees of concern are usually discussed at the Complex Behaviour Meeting (CBM), which is discussed below.

Complex Behaviour Meeting (CBM)

Whilst not discussed within the *Case Management Procedures Manual*, the Review Team had the opportunity to discuss with Transfield, and observe CBM meetings which focus on transferee's who have been placed on Behavioural Management Plans (BMP) or, prior to a BMP, have general behavioural issues that warrant discussion around strategies to manage these behaviours in the OPC environment. In addition to discussing transferee's with behavioural concerns, it appears the CBM is also used to discuss other vulnerable transferee's not necessarily from a behavioural perspective, although this does not appear to be consistent across both sites (discussed under review of each OPC location). The Review Team considers the use of the CBM to discuss other vulnerable transferees appropriate given it provides another avenue for service providers to raise transferees of concern relating to a variety of issues, not just those at risk of significant deterioration or harm (as discussed at PSP/SME). Given there does not appear to be a formal procedure or understanding amongst services providers for using the CBM for this purpose, Transfield Security way wish to consider expanding or consider re-badging it to a title which suggests it focuses on discussing transferees from both a behavioural and general vulnerability perspective.

Recommendation 29: The Review Team recommends that Transfield Security consider formally expanding the CBM to include a focus on discussing other vulnerable transferees, not just from a behavioural perspective, to enable the sharing of information between service providers to ensure the holistic care of transferees in the OPC environment. Transfield Security may wish to consider the development of a 'terms of reference' to ensure a clear understanding of the use of this meeting and expectations of stakeholders in relation to the provision of information sharing. This could be raised at the Weekly Departmental Review meetings (WDR) to ensure stakeholder agreement and formal sign off.

As discussed under the IMP, the CBM could also be used to assist in informing IMP reviews as it enables case managers to obtain updates from service providers regarding particular areas of need as well as discussing appropriate strategies for managing a particular vulnerability or need.

Behavioural Management Plans (BMP)

As mentioned, Transfield Security implemented a BMP process for the purpose of managing transferees with behavioural issues and/or those involved in a number of incidents of concern. Whist Transfield Security are responsible for initiating the BMP, any service provider, including case managers, can request a BMP should they believe it is warranted based on a transferee's behaviour. The BMP is an agreement between Transfield Security and the transferee on strategies or goals that the transferee needs to work towards in order to demonstrate an improvement in their behaviour. Failing to obtain agreement from the transferee will not prevent the implementation of the BMP however may result in the consideration of strategies for staff working with the transferee in an attempt to encourage positive behaviour.

The BMP process includes significant covert monitoring of the transferee by security personnel to monitor behaviour and to assist in the consideration of other strategies to encourage positive behavioural changes. This can include the employment of 'Behaviour Incentive Excursions (BIE),' which involves identifying particular areas of interest and using these as an incentive for the transferee to adhere to the behaviours agreed to in their BMP.

Transfield Security personnel working in the area of behavioural management are trained to develop rapport with transferees on BMP with a view to encouraging positive behavioural changes. The use of 'Whiskey' officers as well as Cultural Officers is also fundamental for this process as the constant monitoring and engagement promotes the development of positive working relationships and ensures the BMP process remains appropriate and the goals achievable. As discussed above, the CBM is the primary mechanism used to review the BMP and to ensure service provider collaboration and information sharing.

Transferee Consultative Committee (TCC)

TCCs are held on a monthly basis, by compound, with community leaders who have been nominated for each of the compounds. The meetings are chaired by the Welfare Services Manager and representatives from each of the service providers are present at the meeting. s. 22(1)(a)(ii) On Manus Island, the Review Team observed four TCCs held over the 4th and 5th of April 2014. These will both be discussed in further detail later in the report.

5.7 Requests & Complaints

A requests and complaints system has been established by Transfield at both OPCs. At both centres, it was evident that the processes are still in their early stages and that there needs to be some refinement of the system, in particular, in getting stakeholders to respond to complaints in a timely manner. The current complaints procedure consists of the transferee receiving an acknowledgement of their complaint within 24 hours. They are then provided with an update after three days, then again at seven days, and a follow-up acknowledgement letter every seven days until the complaint is resolved. The Review Team identified that this was creating a large administrative burden and have suggested that the day three update letter be removed from the process if possible. It was also suggested that complaints that cannot be resolved by Transfield be closed off rather than continuing to be reviewed every seven days. An example of this is the large number of complaints arising from the incident on Manus. Many of the complaints relate to the way that transferees were treated by the police, and requests for information regarding the investigations taking place. It was suggested that a letter be provided to these transferees explaining that all complaints and concerns have been passed on to PNG Police, and that any further response will come directly from them. It should also be explained that as this is a police matter, Transfield cannot provide any further information. This would then allow the complaints to be closed off and would remove the need for continuous administrative follow-up on issues that cannot be resolved.

5.8 Information Systems & Record Keeping

Transfield have sub-contracted their information system development to Community Services.net (CS.net). This is an existing system that is used across 13 organisations in the community services sector, including refugee settlement services, CAS and ASAS. CS.net is working closely with Transfield to tailor the system to meet operational requirements. CS.net is web-based and accessible via a browser without the need to worry about onsite IT infrastructure. As part of their service, CS.net provides a hosting service for storage of all information, maintenance, bug fixing and

user support. There are a large number of reports that are already accessible through the current system configuration and more reports can be developed as required.

CS.net have also been working on a data transfer solution to extract information from the system previously used by the Salvation Army – SAMIS - to record case management/welfare interactions. This information is currently only available in PDF format, however as data can be extracted, it will be loaded into CS.net and Transfield case managers will have access to this historical information.

Stage 1 of the development of CS.net for case management has been configured around creating a case management service for individual cases, structured programs and activities for groups and unstructured programs and activities for unstructured groups. This will allow for recording and reporting on programs and activities attendance by transferees and will assist in the development of additional programs and activities services.

Security protocols built into the system allow the restriction of information to those with appropriate systems access through the security control settings and functionality can be adjusted to suit individual users. Multiple users can be added to each case with varying functionality and security levels to restrict access to only that information that is necessary.

Training on the use of CS.net is being rolled out in April 2014. It is anticipated that it will take approximately 6 weeks to put all case management staff through training with both CS.net and MDA. Connectivity issues are still presenting some challenges on Manus, although case managers have commenced using the system. s. 22(1)(a)(ii)

The Review Team was shown a demonstration of CS.net in the training environment. The system appears intuitive and user-friendly with a logical linkage of transferee information within the client record. Transferees can be linked together in family groups within the system and within this, individual management plan actions can be developed for each individual within the family. case managers enter a series of 'plan items' and within these, a series of 'plan actions' can be listed. As each action is finalised, this can be reflected within the IMP and the historical information will remain within the case plan. Once an action is finalised, the record is closed and cannot be further edited to preserve the integrity of the data within the system.

It appears, however, that CS.net allows case managers to change biodata easily with no obvious control i.e. approval from a senior user. The Review Team expressed concerns with this given the potential to affect data integrity and as well as the potential impact on transferees' RSD process and re-settlement if later found to be owed protection (if identity cannot be verified due to substantial changes in biodata information).

Recommendation 30: The Review Team recommends that Transfield liaise with the Department regarding the establishment of a protocol for changes to transferee biodata information. The Review Team has highlighted the issues surrounding substantial name changes and changes to date of birth. All substantial biodata changes should only be made with approval from the onsite DIBP and supplemented with appropriate evidence i.e. identity documents.

5.9 Handover & Discharge Process

The Review Team notes that a formal discharge process has not yet been established at either site. The Review Team has raised this locally as an apparent omission from the procedures documents. Processes need to be developed for transferees who voluntarily depart, those who are transferred either to Port Moresby or Australia for medical treatment, and eventually, for those who are granted visas and depart the centre. It appears that this process is managed informally at present with the assistance of DIBP staff onsite. Information on medical transfers is retained for the purpose of continuity when the transferee returns however it is the understanding of the Review Team that if the transferee is away for longer than 2 weeks, a new INA and IMP is developed upon their return.

As part of the FIFO model, case managers are required to complete a handover with their replacing case manager to ensure, in particular, transferees of concern are highlighted and appropriate actions/issues are followed up. At both sites, case managers will use a spreadsheet to record handover information about their most concerning transferees, particularly those who require high levels of engagement. For cases with low complexities/vulnerabilities, the case manager will rely on the transferee's IMP and case management notes. Case manager team leaders usually have a one day face-to-face handover as part of the FIFO rotation to allow them to discuss complex cases as well as general staffing issues.

Recommendation 31: The Review Team recommends that Transfield develop handover and discharge processes and incorporate these into the *Case Management Procedures Manual.*

6.0 Review of Welfare Services: Manus Island Offshore Processing Centre (MIOPC).

6.1 Overview

Manus Island Offshore Processing Centre consists of four main accommodation compounds, Delta, Foxtrot, Mike and Oscar. A small compound referred to as Charlie has been constructed to house those transferees who have opted for voluntary return whilst they await finalisation of travel arrangements. Delta compound comprises of a series of demountable buildings in close proximity with little open or recreation space. Transferees are accommodated four to a room with air-conditioning. Foxtrot compound also consists of a series of demountable buildings in addition to a large dormitory-style building which houses approximately 100 transferees in bunks. There is no air-conditioning in this compound. Mike compound is the newest accommodation and consists of demountables/shipping containers arranged in a double-storey configuration with activity rooms, an internet room, classrooms and phones. Oscar compound consists of three marquees with dormitory style accommodation – these marquees are air-conditioned, however there are approximately 100 transferees housed in each marquee. Foxtrot and Mike compounds were the main sites of unrest in February 2014.

6.2 Introduction

Initial Observations (Transition Period)

The Review Team commenced on Manus Island on 14 March 2014 with an introduction to the current situation on the island and the Manus Island Offshore Processing Centre (MIOPC). The mood of the centre was still quite volatile as a result of the recent disturbances and tensions within the centre remained relatively high with the centre security rating at Amber. The Amber rating itself posed significant problems for all service providers, with heightened security measures in place, requiring staff to be escorted at all times when entering the compounds. Locally engaged staff were unable to go back into the compounds due to security concerns and this is impacting on services available to transferees. At the conclusion of the transition of garrison services, Transfield intended to review the security rating of the centre and lower it if appropriate. Case managers from Transfield were assisting in the running of basic services such as the canteen, phone and internet within the compounds which was severely diminishing their case management capacity. This was due to the removal of locally engaged staff who managed most of these services. Transition of services from G4S to Transfield was due to be finalised by 28 March 2014.

After the February disturbances, Transfield was requested to commence welfare and case management services several weeks earlier than originally contracted. With the rapid transition out of The Salvation Army (TSA), Transfield commenced welfare services with limited resources. Existing TSA staff members were offered initial 3-month contracts with Transfield whilst they complete necessary recruitment and training programs. Transfield faced challenges which included not being able to allow locally engaged staff into the compounds, ongoing recruitment processes for many positions meaning that a full staffing profile was not in place, and the need to redirect case managers from their roles to delivering basic welfare services. Recruitment of case managers was continuing through Transfield HR, along with case managers working with the transferees to prepare them for the transition of locally engaged staff back into the compounds to provide welfare services such as the canteen and phones and internet access.

The Review Team acknowledged however, that Transfield was committed to delivering the best possible services with the resources they had available and within the restrictions of the environment at the time. Given their welfare staff were being used for other purposes, the team were committed to at least one interaction per transferee per week, increasing as their staffing profile stabilized. This interim strategy also included the development of local talking points in regards to the transition of Transfield as well as the status of services and when they are likely to be fully up and running (following the disturbances at the centre).

At the time of initial observation, Welfare Services was aiming to implement its full suite of case management and welfare services by a transition completion date of 28 March 2014. Due to ongoing implementation, the Review Team, together with Transfield recommended an alteration of the Review Team's itinerary to allow Transfield on Manus Island to continue with their transition and allow them to implement the model they intend to deliver. s. 22(1)(a)(ii) [redacted] The Review Team returned to

Manus Island on 31 March 2014.

Post-Transition Review

On returning to MIOPC on 31 March 2014, it was evident that some progress had been made in relation to the delivery of the full suite of welfare services, however, as the transitioning of locally engaged staff back into the compounds had not yet commenced, staff shortages meant that many case management services were affected. In addition, stock shortages following the transition out of G4S meant that requests for personal items such as clothing and canteen items were not being fulfilled in a timely manner and this certainly added to the tensions amongst the transferees.

The Review Team noted however, that Transfield continued to demonstrate considerable efforts in order to improve services and deliver their welfare program at full capacity. Immediately following the finalisation of the transition period on 28 March 2013, Transfield, based on intelligence information from their security team and general observations regarding decreased tensions, reduced the security risk profile of the centre to 'low' which meant that some services could resume and the impact on staffing resources i.e. security escorts for staff was reduced. In addition, Transfield lifted the restrictions on the compounds by implementing an 'open centre' policy – removing the locks and opening compound gates to promote a more trusting community environment. Although free movement by transferees is still not in place (they are still escorted to appointments etc.), the opening of the gates was well received by the transferees. The Review Team, through observations and some discussions with transferees, noted that positive feedback in relation to the comparison of services from G4S to Transfield and Transfield Security (Wilson Security) was received. The main concern from transferees was the provision of requests for clothing items, responses from IHMS in relation to medical concerns, particularly dental as well as inconsistencies of services between compounds i.e. some compounds still did not have their own internet service at all (a plan is being developed to share internet services between compounds) as well as telephone reception. It was evident, however, that Transfield were exploring options and committed to improving these services and this was communicated to transferee's through the Transferee Consultative Committee (TCC) with some timeframes provided for expected improvement in services.

In terms of welfare services, the Review Team noted that the main focus area for Transfield was the transition of locally engaged staff back into the compounds to facilitate basic welfare services such as the canteen and meal service. Once this has occurred, case managers will be able to focus on their role and more meaningful engagement with transferees. Recruitment and training continues to be a huge focus, with staffing levels not up to the level to allow for full implementation of welfare services. As at 8 April 2014, formal case management training had not yet commenced, however plans are in place for this to commence within the next few weeks. Finally, in relation to programs and activities, the re-introduction of excursions was also a priority and Transfield has done considerable work with the community in order for these to re-commence and promote positive engagement between the transferees and the local community. As at 8 April 2014, beach and running excursions had commenced.

From the perspective of the Review Team, it is evident that further progress is required in relation to

the development of working relationships between service providers, namely, between IHMS and Transfield to allow for the provision of effective information sharing and understanding of the level of service between providers. This is essential for the development of individual management plans and ensuring they remain current and appropriate to the changing needs of the transferees.

6.3 Staffing Model and Training

During the review period, Transfield had 28 deployed case managers on Manus Island and four case management team leaders. The Welfare Service Manager and the Case Operations Manager positions have both been filled, and whilst the Review Team was on site, new staff continued to arrive. It is the understanding of the Review Team that all positions have now been recruited for, however there will still be a lead-time before all commence their roles. Case managers held a caseload of 25-35 transferees, however this is expected to be reduced to a caseload of 25 once all case management staff are on board.

s. 22(1)(a)(ii)

. It is understood that case managers will attend training over the next few months during their time back in Australia between deployments. At present, case managers are provided with a basic induction upon commencement at the OPC which focuses on an introduction to the environment and the service providers. This is complemented with a mentoring system using case managers with previous experience. It was noted that this is quite resource intensive and not the most effective way of training new staff members. There are also concerns with this method that levels of training will be inconsistent and that there is a risk that best practice will not be consistently applied. The Review Team has noted this with the Welfare Service Manager and emphasised the need for formal training to be rolled out as soon as possible to prevent bad habits from forming. Whilst the Review Team was at the OPC, CS.net was starting to be rolled out. There were some connectivity issues and a shortage of staff computers, however it was encouraging to see that the rollout had commenced.

PsyCare provides onsite counselling and support for all Transfield Staff, along with presenting 'Toolbox Talks' on self-care and staff related topics. As part of the on-going support and care of welfare staff, Transfield employs a mandatory debriefing with PsyCare at the conclusion of the 2-week deployment together with a re-introduction session upon return to the centre at the beginning of each deployment swing.

6.4 Stakeholder Relationships & Information Sharing

From the observations of the Review Team, relationships between stakeholders appear to be quite strong, although at a very early stage. DIBP on Manus Island should take the lead in encouraging greater stakeholder relationship building and encourage a culture of information sharing. The general structure of the OPC needs to be made clear to all staff working there and a greater understanding of DIBPs role within the centre is also required. PNG Immigration need to be encouraged to communicate more with all stakeholders and provide updates on processing of RSD claims. Whilst it is accepted that timeframes are difficult to provide, some indication needs to be given around how long interviews will take, when they are likely to be scheduled and an indicative timeframe regarding how long transferees should expect a decision on their claims to take.

6.4.1 Transfield Security (Operated by Wilson Security)

The relationship between Transfield Security and case managers is still in its early stages, however initial impressions are quite positive. There is scope for better communication protocols to be developed and entrenched between these two arms of Transfield. This was discussed with team leaders, particularly from the perspective of sharing security information and intelligence. For example, case managers have not been informed about some of the weapons that have been found in the compounds and as a result, case managers appear to be quite complacent about their personal security. Whilst the intent is not to scare them, information sharing is essential to ensuring the safety of case managers in the compounds. The Review Team would encourage case managers and the security teams to have some joint training sessions on information sharing, how to complete incident reports and lines of communication for reporting any intelligence gathered within the compounds (**refer to Recommendation 24**).

The Review Team also encouraged case manager team leaders to implement a culture of checking in with the compound guard hut before entering any of the compounds – checking on the temperature of the compound, whether there have been any incidents and letting the guards know where the case managers intend to be during their visit, any individuals they may be meeting with and how long they intend to be in the compound. Some team leaders did not share the same levels of concern as the Review Team and as a result, there are some concerns about the culture of security awareness and personal safety that could develop. After running an information session for team leaders around how to improve personal security, professional boundaries and setting up interview rooms to improve the security for the case manager, interpreter and the transferees, the Review Team felt that there was a greater understanding of the need for strong security awareness. This also highlighted the need to develop strong relationships between case management and Transfield Security to ensure timely sharing of information and an understanding of the centre at all times. The Review Team recommends regular security briefings and personal security awareness training for all staff within the OPC.

Recommendation 32: The Review Team recommends that a protocol of regular (daily) briefings to case managers be considered which covers the temperature of the centre and a summary of incidents to ensure staff are aware, and remain mindful of their safety and security during compounds walks.

6.4.2 IHMS

The Review Team met with the Health Services Manager (HSM) to discuss the sharing of information with case managers. There are currently no formal structures in place and this was raised as an area of concern by the HSM. To assist with the communication process, the Review Team developed a fact sheet on the amount of information that case managers could expect to receive from IHMS – this was agreed to by both the HSM and the Welfare Services Manager and will be distributed to all case managers. The Review Team also identified the need to set up a better communication system – at present, a case management team leader goes to IHMS once a day with a list of queries including

whether/when appointments have been scheduled. The Review Team highlighted the need for case managers to encourage greater self-agency by transferees as well as teaching them to follow up on their own appointments through established procedures.

A common complaint received from transferees at the TCC was the lack of basic painkillers being available without the need for a request form to be completed. Agreement was reached at the TCC that Panadol will be available at all guard huts and a register kept to monitor dispensing of medication. This should allow transferees to seek pain relief immediately and also markedly decrease the number of requests for medical appointments. It was surprising that this arrangement had not already been implemented as this is common practice at onshore facilities, however it was encouraging to see that it was implemented so quickly.

The Review Team also identified a lack of knowledge regarding the service delivery standards adhered to by IHMS in regard to waiting periods for medical attention, the services that are available at the OPC compared to those that require referral to specialists in the community, and the current community standards for health care. Education of case managers in this area should go some way to managing transferee expectations and educating transferees on what services are available.

Recommendation 33: The Review Team recommends that an agreed communication protocol is developed between Transfield and IHMS regarding the sharing of transferee personal medical information on Manus Island. This should be in addition to Recommendation 21 regarding a new consent process.

Recommendation 34: The Review Team recommends that a 'Toolbox Talk' be developed that outlines the medical services available to transferees on Manus Island and the service delivery standards that IHMS works to. This may also include development of a standard 'tip sheet' on IHMS service provisions for case managers to ensure consistent understanding and messaging to transferees.

6.5 Initial Needs Assessment (INA) & Individual Management Plan (IMP)

At the time of the review, Transfield was still transitioning their welfare services from TSA which included the development of a new IMP for all transferees. Some information gathered by TSA had been provided, however this was not in a transferrable format so a new initial IMP needed to be developed. The Review Team had the opportunity to view a sample of completed INAs and IMPs provided by the case management team and it appears they are capturing relevant information needed for the appropriate care of the transferees. Some minor feedback was provided, primarily in relation to case managers being more explicit when they identify a particularly need and whether they have clearly explained what services are available to a transferee (or made relevant referrals).

The Review Team notes that case managers were working with very limited systems access and that CS.net had not yet been rolled out in its entirety. Case managers were recording case notes in

Microsoft Word documents which will need to be migrated over to CS.net when it is fully operational.

6.6 Behavioural Management

Transfield Security on Manus operates the behavioural management program based on their own intelligence gathering as well as input from all other service providers. s. 22(1)(a)(ii)

The most obvious issue surrounding behavioural management on Manus is a lack of restrictive and supported accommodation units. With the current infrastructure available there is a risk of situations escalating very quickly and there is an inability to separate troublemakers from the general transferee population. Without any restrictive detention areas within the OPC, there is little scope for Transfield Security to manage poor behaviour without having to involve the police if a transferee needs to be removed from the compound. Without supported accommodation, there are limited options for providing support to transferees who may need to be separated from their compound due to physical or mental health issues. Self-harm incidents are increasing and this is likely to continue with prolonged detention, and a lack of certainty surrounding processing and the future. At the TCC, it was raised that there is very little privacy available to transferees who may be on regular or constant watch, along with the disturbance this causes to the other occupants of the rooms or dormitories. If transferees engaging in self-harm behaviour are not able to separated from the general population if required, this can be a cause of angst for other transferees and can escalate their behaviour in some situations.

From the interactions witnessed by the Review Team, Transfield Security has started building a good rapport with the transferees – they treat the transferees with respect and the company culture appears to be supporting this approach. Most of the security staff are from a military or policing background as opposed to the prison guard background that has been seen in detention centres in recent years. The difference in demeanour is apparent immediately and there appears to be a greater level of respect and trust between transferees and the security team.

6.7 Programs and Activities

Programs and activities have been extremely limited on Manus since the February incidents. Most of the P&A staff were locally engaged, and since the incident, have not been allowed back into the compounds. Staff-led activities within the compounds are very limited as the majority of these were delivered by local staff. Recently a beach excursion has been introduced and a walking/running group around the Lombrum Naval Base. Transferees are able to self-nominate for these excursions, however must have first received a PNG Health Clearance. To date, only approximately 500 transferees have received this clearance – Transfield is working closely with IHMS to progress clearances for the rest of the transferee population.

Recommendation 35: The Review Team recommends that priority be given to ensuring all transferees (on Manus Island) have a PNG Health Clearance so they can participate in excursions.

The Review Team discussed future plans for P&A on Manus and the intent is that activities will be expanded significantly, with more structured education classes along with assessments and electives being implemented.

Supplies through the canteen have been quite limited under the previous service provider, and during transition, there have been disruptions to the supply process. The P&A team noted that they have ordered more activity based items that will be available to purchase through the points system including items such as playing card, carrom boards, religious texts, art supplies and games. The Review Team was impressed with the thought and planning that has gone into providing more meaningful activities and fostering a sense of ownership and responsibility by making these items available for purchase through the canteen.

Recommendation 36: The Review Team recommends that once locally engaged staff have been reintegrated back into the compounds on Manus Island, continual review of P&A be undertaken with transferee input into both formal and transferee-led activities where possible.

6.8 Transferee Communication & Engagement

From discussions with the Welfare Services Manager and case manager team leaders, it appears that there are currently no structured compound walks, transferee appointments or a shopfront. The Review Team explained the importance of creating a structured communication and engagement strategy that allows for regular engagement whilst encouraging greater independence and self-agency for transferees. With the current approach, case managers spend a great deal of time looking for transferees they need to speak to, particularly regarding requests and complaints. The implementation of structured compound walks or a shopfront would encourage transferees to book appointments or seek out their case manager at a specific time, along with allowing requests and complaints to be resolved in a more timely and efficient manner. Interpreter resources would also be able to be used more efficiently with a structured shopfront schedule. It was also noted that there is a lack of access to interview rooms within the compounds. Implementation of an appointment system would allow greater use of interview rooms that may be available in 'E' block, along with more effective use of interpreters.

Recommendation 37: The Review Team recommends that a more structured communication and engagement strategy be implemented as a priority, to enable more efficient use of time and interpreter resources, whilst encouraging greater independence amongst the transferees.

6.9 Stakeholder Meetings

6.9.1 PSP/SME

The PSP/SME meeting is held on a daily basis and is managed by IHMS and attended by all service providers to provide input in relation to transferees of concern. The Review Team have concerns regarding DIBP representation at these meetings, as the role has no requirement for any background in either case management or client services. It was noted that many of the transferees on the PSP/SME list were quite vulnerable and the Review Team feel that it is imperative that the DIBP representative at this meeting have experience

in working with stakeholders to find effective strategies for dealing with particularly vulnerable transferees and escalating cases where appropriate. As discussed in the section on IHMS, there is a need for an enhanced consent process to allow for greater information sharing between stakeholders at both the PSP/SME and the Complex Behavioural Meeting.

In discussions with case managers, it was noted that the communication process for informing case managers when their transferees are on PSP needs improvement. The current process is for a list of transferees on PSP to be written on the whiteboard in the case management office. The Review Team discussed with the case management team leaders the need for more detailed information to be passed on to individual case managers in a timely manner to avoid situations where the case manager may unknowingly engage with a transferee when it is not appropriate. Team leaders were concerned about giving out too much information, however the Review Team discussed the rationale behind this and that the case manager may exacerbate the situation unknowingly if they were not aware of the reasons behind a client being on PSP – for example, a transferee just being notified of a death in the family etc.

6.9.2 Complex Behaviour Meeting (CBM)

The Complex Behaviour Meeting is held on a weekly basis straight after the PSP meeting. From observations by the Review Team, it appears that there is an excellent understanding by Transfield of the issues involved and the limited practical solutions available. A particular strategy of note is the use of Behavioural Incentive Excursions (BIEs) to encourage and reinforce good behaviour with transferees. Whilst this strategy is currently successful the Review Team would caution that this approach may have a limited lifetime as it will not take long in an OPC environment for this strategy to become known amongst the transferees – this could lead to manipulation of the system and issues between transferees if it is identified that another is getting more privileges.

As discussed in Section 5.7, there is an opportunity to expand the scope of this meeting to discuss vulnerable individuals before their behaviours escalate to the point where they may require a Behavioural Management Plan (BMP). The Complex Behaviour Meeting (CBM) meeting may also be an appropriate forum at which to discuss IMP reviews. These could be done on an exception basis whereby the Welfare Service Manager reviews 25% of all Individual Management Plans (IMP) per week and put forward any cases of concern for discussion at the CBM. With all stakeholders present, a list of those reviewed in that week could be tabled and signed off, thus allowing all IMPs to be reviewed on a monthly basis.

6.9.3 Transferee Consultative Committee (TCC)

Representatives from each compound were invited to attend the meeting which was held in the Bravo compound. Representatives from Transfield included the Welfare Services Manager, the Security Manager and the Operations Manager. Also present were the Health Services Manager from IHMS and a mental health team leader, an IOM representative, case management team leaders and the Emergency Response Team (ERT) for security. There were no representatives from PNG Immigration, which was problematic for the transferees

as this has been the only meeting at which they can obtain information about processing. The chair of the meeting clearly stated at the beginning that the only topics that could be discussed at the meeting were those relating to welfare, access to medical services, accommodation, catering, security and programs and activities. It was made clear that processing could not be discussed as the appropriate representatives were not present and that queries should be kept general to the whole transferee population, not just specific cases. It was also explained that DIBP presence at the meeting was not to discuss processing, but was in a contract management capacity to make sure that transferee concerns were being addressed by the service providers.

The Review Team was able to observe the TCC for each of the four compounds. These were the first TCCs to be facilitated by Transfield. Over the series of TCCs, the strength of messaging and control of the meetings improved. Overviews were given by each relevant area and the meeting was then opened up for general questions. Whilst some transferees were insistent on discussing matters only relevant to themselves, the meetings were kept well focussed and transferees were encouraged to act as representatives of their groups within the compounds and discuss issues of wider concern. The Review Team is confident that these meetings will improve over time and become more focused on relevant issues.

Of note however, was the absence of any representatives from PNG Immigration. Transferees were advised at the beginning of the meeting that no questions regarding processing could be raised. The transferees did query what the appropriate forum would be to do so as they have concerns regarding processing and are wanting more information.

Recommendation 38: The Review Team recommends that DIBP and Transfield on Manus Island invite PNG Immigration to attend the TCC meetings, or alternatively, set up another more appropriate forum for discussing the processing of claims and to provide general information about the broader assessment and resettlement process.

6.10 Requests and Complaints

A large number of the complaints being dealt with on Manus relate to the February incidents and the ensuing investigations. Many of the complaints related to treatment by former service provider staff and the PNG police. The Review Team discussed the current complaints process and the need for updates on outstanding complaints every 7 days. It was identified that many of these complaints involve issues that are beyond the control of Transfield and they have been referred on for investigation or response by the PNG police or investigators. It has been suggested that if no further action can be taken by Transfield on these matters, that this be explained to the transferees in a written response and the complaints be closed.

Since Transfield have taken over responsibility for welfare services there have been an overwhelming number of requests for clothing packs. There are been supply issues with getting new stock to Manus Island, however full stocks were expected within approximately 3 weeks. Transfield plans to use up existing stocks over the next few weeks and spread the supply evenly between the compounds. This will make the supply of clothing and personal items more sustainable and create

too much additional pressure on case managers who are currently undertaking many of the basic welfare tasks until local staff are reintegrated back into the compounds.

With the recent transition of service providers, local staff not yet being reintegrated into the compounds and case managers assisting with the processing of requests and complaints the Review Team acknowledges that Transfield is doing a good job under the current circumstances.

6.11 Information Systems and Record Keeping

Transfield is currently rolling out access to CS.net for all case managers on Manus Island. There are some issues being experienced with the bandwidth required to run CS.net simultaneously on multiple computers, however the IT team are working through these issues. Case managers are currently being trained on the use of CS.net whilst they are off island and on-site support is provided for those who have not yet been through the training. The Review Team understands that there are plans to utilise more features of CS.net over time including allowing transferees to electronically book themselves into activities and excursions (through a kiosk system). Whilst it is still early days in terms of the roll out of CS.net, the Review Team was impressed with the system and once the technical issues are resolved, believe it will be a very useful system.

The migration of data from TSA into CS.net is continuing. Unfortunately this will only be in PDF format and any relevant information will need to be manually extracted and entered into new IMPs. Once all data is available, case managers will have greater visibility and understanding of historical issues with individual transferees which will improve their ability to manage individual cases.

The Review Team spent some time with case managers looking at their case notes and was impressed with the quality and detail included. Development of IMPs was due to commence as the Review Team completed their deployment which will be the first time CS.net is used for IMP development.

6.12 Summary of Findings & Conclusion

The Review Team was impressed with the progress that has been made by Transfield at this stage of the transition process considering that systems are not fully operational, the large backlog of complaints and requests from G4S/TSA, low stock availability, difficult working conditions, and the reintegration of local staff into the compounds not yet being complete. There are some areas that need a greater focus, such as ensuring training materials and manuals are completed and available to all staff, formal training sessions are implemented as a priority and getting the full complement of staff on site. Once local staff are reintegrated into the compounds, case managers should be able to focus on the management of welfare for their transferees. The reintegration of local staff into the compounds will also allow programs and activities to be reinstated, which in turn will benefit the welfare of the transferees.

The lack of clarity around the Refugee Status Determination process is of concern to the Review Team along with the lack of information available to case managers to assist in managing transferee expectations. The Review Team recommends that 'Toolbox Talks' be developed to provide information to case managers around the processing of claims and provide a basic understanding of the process. Whilst case managers will not be involved in the delivery of any decisions, an

understanding of the process is essential as case managers are the primary contact point with transferees.

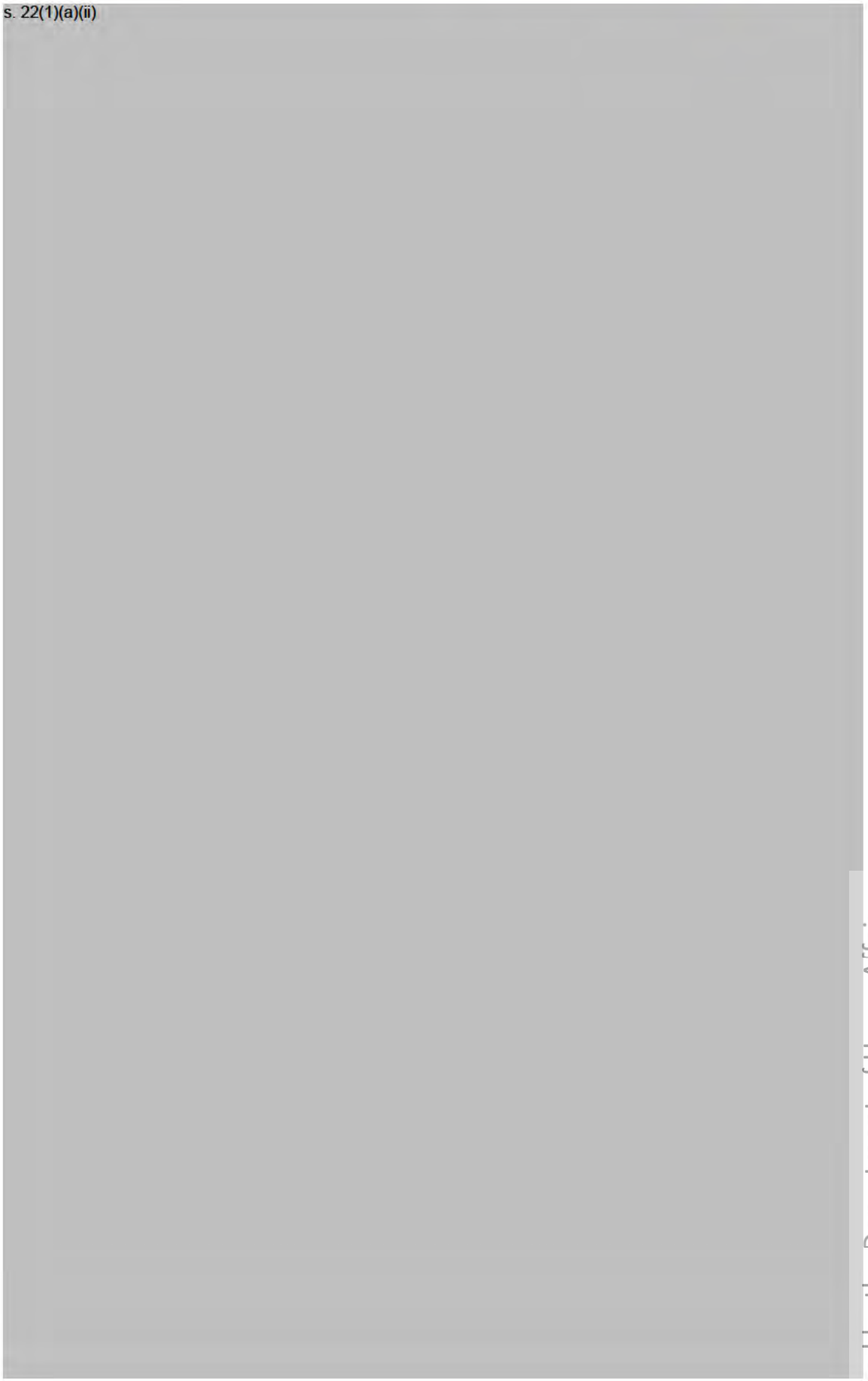
Recommendation 39: The Review Team recommends that Transfield and the Department consider brief training or an information sheet for case managers regarding the RSD process to provide a consistent understanding of this process to assist in managing Transferee expectations.

Based on observations, the case management team appear committed to their role, and have shown a great deal of flexibility whilst taking on additional basic welfare provision within the compounds, along with the added pressure of not having a full case management staffing profile. As a priority, Transfield should focus on finalising their full staffing compliment on Manus Island to ensure the effective roll out of the case management model. This includes finalisation of staff training to ensure a consistent understanding of case manager obligations and an understanding of the environment.

s. 22(1)(a)(ii)

s. 22(1)(a)(ii)

s. 22(1)(a)(ii)



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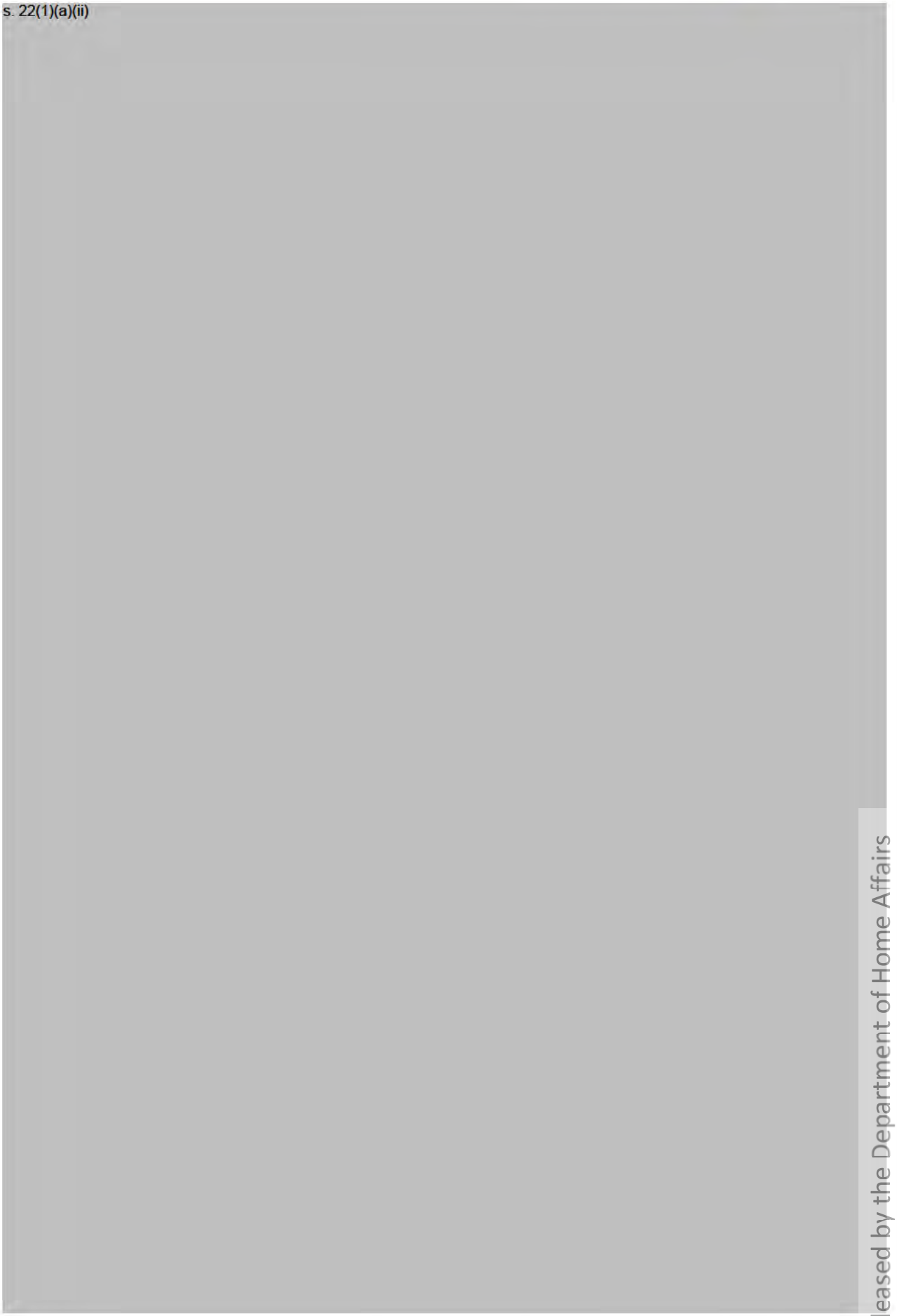

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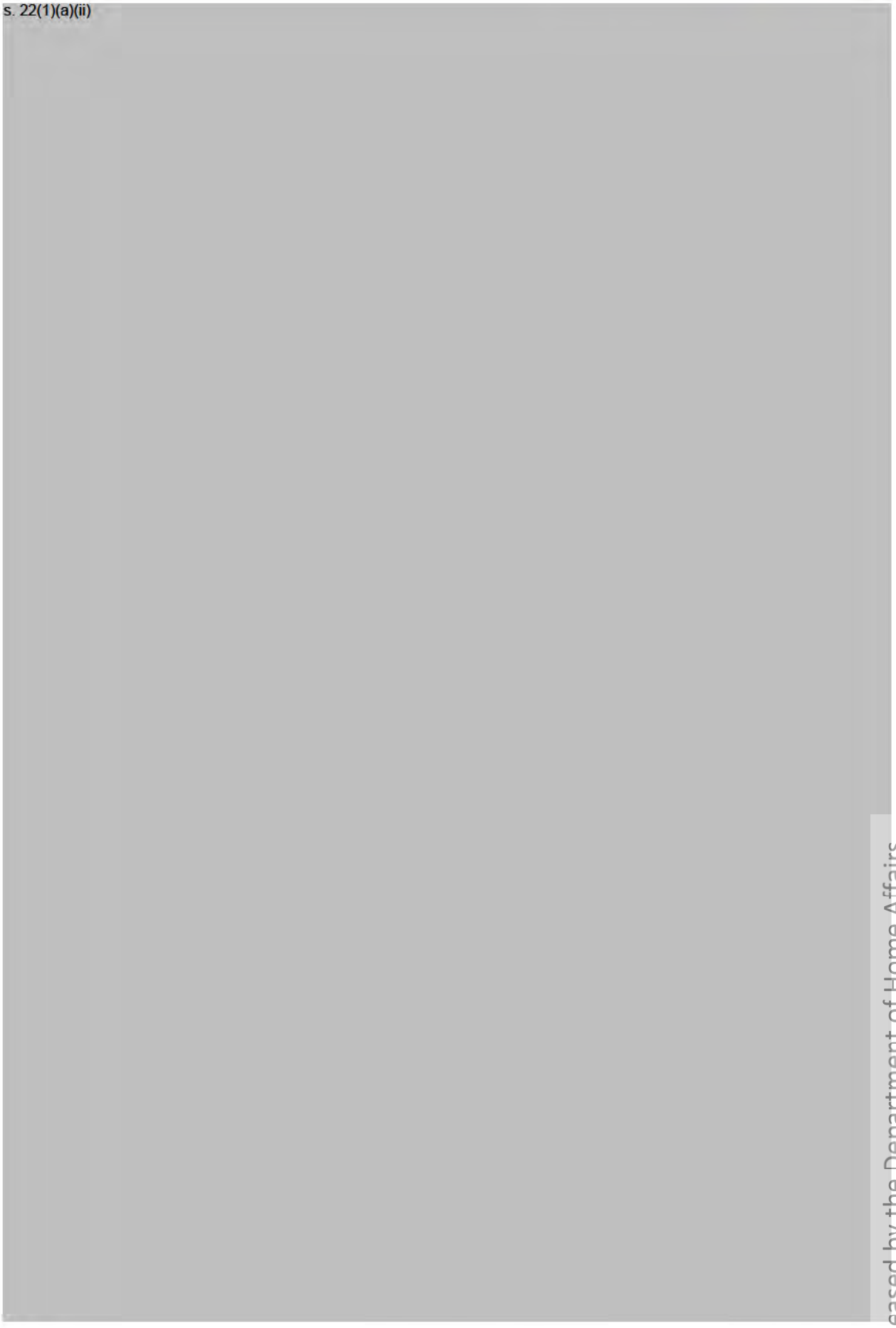

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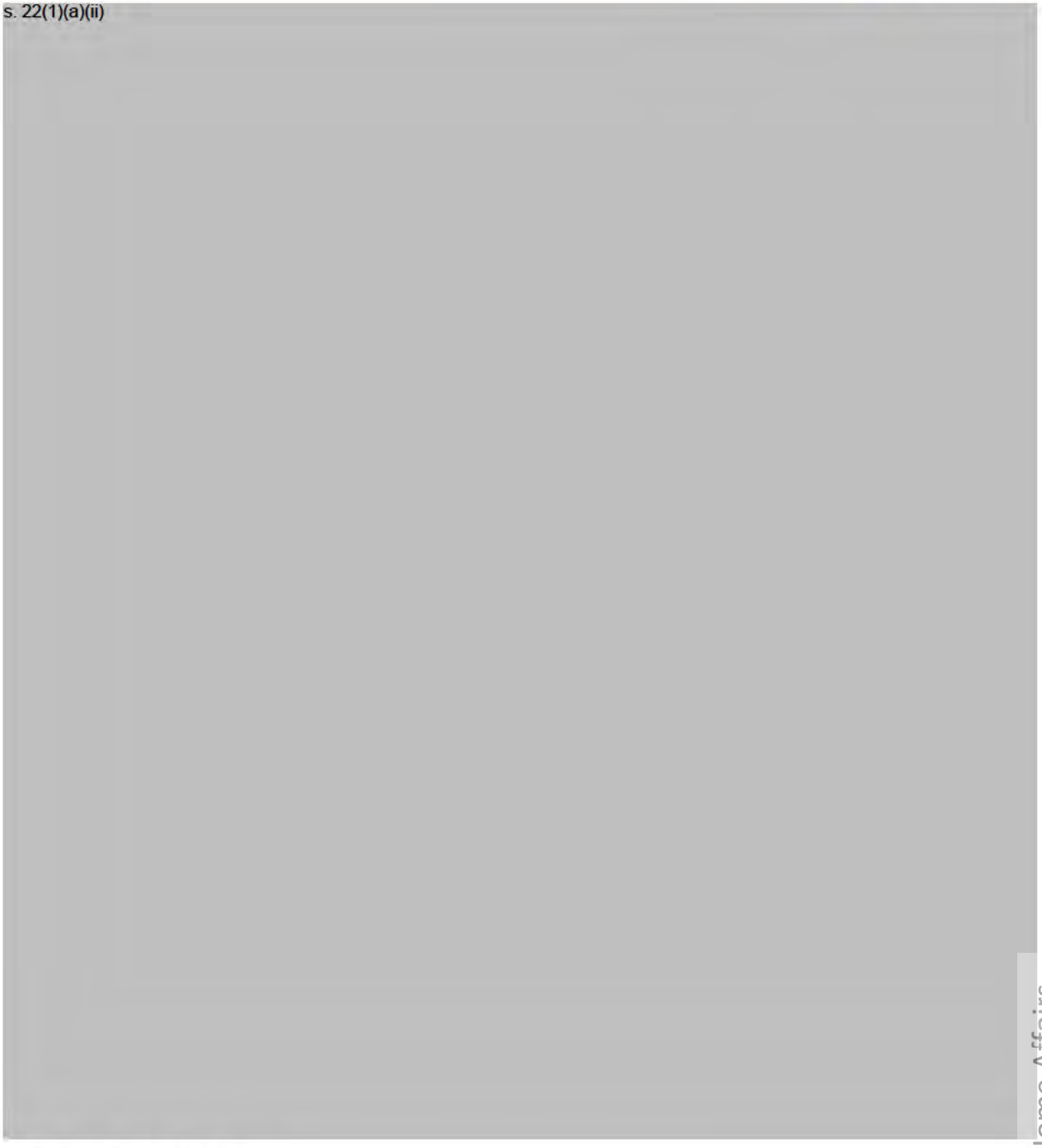


8.0 Conclusion

The Review Team considers that Transfield has taken positive steps to ensure the effective implementation of its welfare services program. Although there are some limitations as a result of the environments, Transfield are working positively with service providers to ensure the roll out of welfare services are suited to the changing needs of the transferees and the complexities associated with the OPC environment.

In terms of the case management model, Transfield appear to have a good grasp of their obligations in relation to the appropriate design of care plans and subsequent review to ensure the individual circumstances and needs of the transferees are considered and managed accordingly. However, the

Review Team recognises the need to implement the full suite of case management training for staff at both locations in order to prevent inconsistent practices amongst case managers who come from a variety of different backgrounds and disciplines. In addition, case management staff need to be supported with structured and detailed procedures documents to ensure a holistic understanding of their roles as case managers as well as the environment they work in.

Information sharing protocols are another area of high importance, particularly between Transfield and IHMS, given the importance for IMPs to capture transferee needs and medical issues that may impact on their management within the OPCs. Transfield, together with the Department, should focus on developing these protocols as a priority.

Given the review was conducted very much during the transition phase in which welfare services were transferred to Transfield, the Review Team considers that a further review would be beneficial in 3-6 months to evaluate the progress once all systems are in place and a full staffing compliment is available.

During conversations with the Transfield management team, it was identified that the deployment of an experienced DIBP case manager to work alongside Transfield to assist with the development of policies and procedures and also to assist with workplace training of case managers would be beneficial. This could potentially be added to the role of 'Status Resolution Officers' which the Department is currently developing with a view of deploying these officers to both locations shortly.

Recommendation 45: The Review Team recommends that the Department consider a further review of welfare services to be conducted within 3-6 months to evaluate progress following full implementation of systems and staffing model.

Recommendation 46: The Review Team recommends that consideration be given to the deployment of a DIBP Officer with case management experience to assist with the development of policies and procedures and the training and mentoring of case management staff. This could be incorporated into the 'Status Resolution Officer' role that the Department is currently considering for offshore deployments.

Assessment of Emergency Medical Capability and Capacity PNG 2016

s 22(1)(a)(ii)

Table of Contents

Executive summary

s 22(1)(a)(ii) was engaged by the Department of Immigration and Border Protection (the Department) to provide an overview of current capacity and capability of health services contracted by the Department as well as local services available to respond to a health emergency on Manus Island and in Port Moresby.

This report reflects the observations and views of s 22(1)(a)(ii) based on his assessment at the time.

An assessment of emergency capacity relating to the care of staff, transferees, refugees and other stakeholders was carried out by visual inspection and interview.

Sites and elements assessed included:

- the medical clinic at the Regional Processing Centre (RPC) on Manus managed by the Department's contracted health services provider, International Health and Medical Services (IHMS);
- the public hospital at Lorengau including issues pertaining to accessibility;
- the privately run Pacific International Hospital (PIH);
- Port Moresby General Hospital; and
- the IHMS-run community support team based at the Granville Hotel, Port Moresby.

An assessment of the capacity of the system as a whole, as well as individual elements, was considered. Strategies to manage cases in time of normal demand and surge demand were also considered.

1. Terms of reference

1.1 Methodology

The methodology used to undertake assessment and observations in this report included:

- field visits;
- semi structured interviews;
- audits; and
- triangulation and verification of key identified issues.

1.2 Consultation

The following personnel were interviewed in preparation of this report:

IHMS:

- Senior Medical Officer
- Senior Nurse
- Health Services Manager
- MH Team Leader

Australian Border Force:

- Programme Coordinator

Lorengau public hospital:

- Medical Director

PIH:

- Medical Director

Port Moresby General Hospital:

- CEO

2. Recommendations for Port Moresby

Port Moresby is well placed to receive cases from both Manus Island s. 22(1)(a)(ii) . Port Moresby is about two hour's transit time from Manus Island airport s. 22(1)(a)(ii) . There are two hospitals in Port Moresby, a private hospital (PIH) and a public general hospital both situated 16 minutes' drive from the airport.

The general hospital is busy, with 1000 presentations to the Emergency Department (ED) a day and s 33(a)(iii) The hospital is clean and has made significant improvements over the last five years. s 33(a)(iii)

Recommendation:

That a surge capacity/ mass casualty response plan involving the whole system needs to be formulated, documented and widely understood.

The PIH is a private hospital staffed with specialist staff, many of whom trained in India, United States of America (USA) and Australia. They are supported by junior staff and work in a well-equipped modern hospital. While not all specialties are catered for, there is a group of specialists registered in Papua New Guinea (PNG) who reside in India who could be called on at short notice. The range of facilities available includes Computed Tomography (CT) scan, Magnetic Resonance Imaging (MRI), Catheterization Laboratory, echocardiography and dialysis. A well-equipped ED is supported by theatres and a high dependency unit with ventilator capacity that has the potential to meet the expectations of a tertiary ICU when an Internist who has been recruited arrives.

This facility is supported with pathology services and a blood bank. The Australian Federal Police (AFP) has a separate blood bank with only three units at this site. Staff are well trained but lack the opportunity to keep up to date with current trends.

Recommendations:

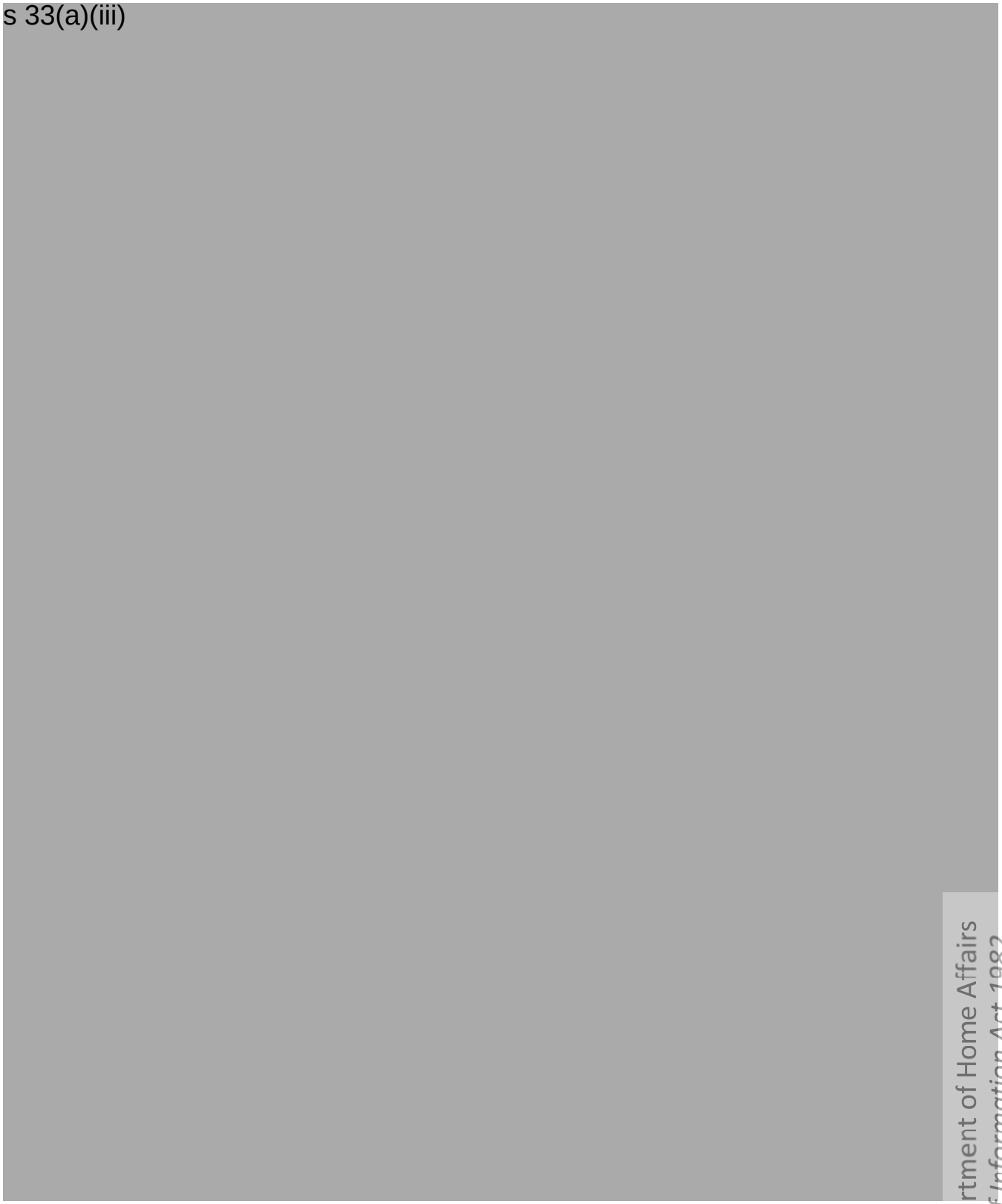
PIH represents an appropriate venue to manage staff, transferees, refugees and other stakeholders, which could be enhanced with the involvement of staff from Australia in the team.

There is a possibility that identified Australian specialists could be pre-registered as PIH affiliates in a similar model to that used for the existing external specialist pool.

s 33(a)(iii)

PIH hospital would make an appropriate place for mounting a surge capacity response.

s 33(a)(iii)



4. Recommendations for medical referrals to Port Moresby

Staff, transferees, refugees and other stakeholders who are referred to Port Moresby for treatment and assessment are supported by a community team, which consists of nursing clinicians. This team is operating without immediate back up and without appropriate first response equipment.

Recommendations:

The clinical governance of this team should be reviewed and documented.

A first response kit should be provided.

s 33(a)(iii)

This group requires clinical support from a GP and admin support to manage the administrative tasks.

Consideration to a written briefing process covering the expectations of staff, transferees, refugees and other stakeholders undergoing treatment is recommended.

5. Port Moresby General Hospital assessment

Port Moresby General Hospital serves not only the population of Port Moresby but also to referrals from the whole country. There are approximately 1000 ED presentations per day. Patients presenting are triaged according to the Australian five point triage system with only Triage 1 and 2 entering the main ED. Triage 3, 4 and 5 are dealt with in a different clinic.

The ED has 28 beds and like Australian hospitals suffers from bed block. There are 10 direct admission beds for medical and 10 direct admission beds for surgery to alleviate workflow issues.

X-rays are available via an electronic system; s 33(a)(iii) The ED has three beds that are deemed resuscitation; these beds have monitors and there is a monitor/defibrillator and an ox log ventilator in this area and a drug trolley containing modern drugs. s 33(a)(iii) There is a store of equipment in ED, which contains 22 infusion pumps and two Electrocardiography (ECG) machines as well as non-invasive blood pressure monitors and two pulse oximeters.

(ED store)

The lead ED doctor has fellowship qualifications, as does the lead ICU doctor. There is a Vascular Surgeon who is USA trained on staff.

The workload consists of a significant number of trauma victims, infections including Tuberculosis (TB) and snakebite victims who arrive from rural areas. s 33(a)(iii) Cardiothoracic Surgery and Cardiology services are offered and Cardiac Pacing (pacing) is offered. Surgical management tends to be by open surgery s 33(a)(iii) There is a CT scanner and an MRI installed s 33(a)(iii)

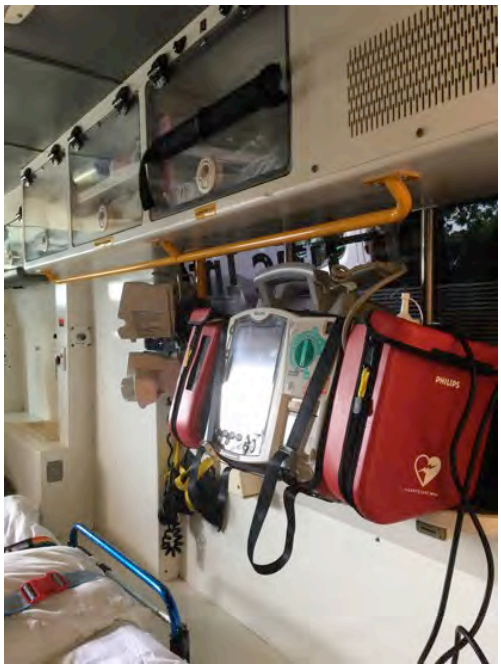
The hospital has seven ICU beds s 33(a)(iii) there are three coronary care beds and a high dependency step-down unit with 30 beds. ICU contains seven beds and all are equipped with ventilators s 33(a)(iii) Central venous pressure monitoring occurs via traditional manometer techniques. The choice of inotrope is dopamine. There appears to be a good selection of standard drugs. There is a defibrillator located in ICU with a life pack of 15. s 33(a)(iii) it is a clean efficient environment. This is a huge step forward from the situation that apparently existed five years ago where there was only one ventilator.
s 33(a)(iii)

Overall the hospital is clean and effective working with large demands and a relatively modest budget. Unfortunately projected financial cuts to this budget and the subsequent loss of the CEO raises doubts as to whether these improved standards will be maintained.

s 33(a)(iii)

6. Pacific International Hospital (PIH), Port Moresby assessment

The PIH provides a range of private medical services in Port Moresby. The hospital group is expanding with the acquisition of another hospital in Lae and further beds to be added to the existing hospital.

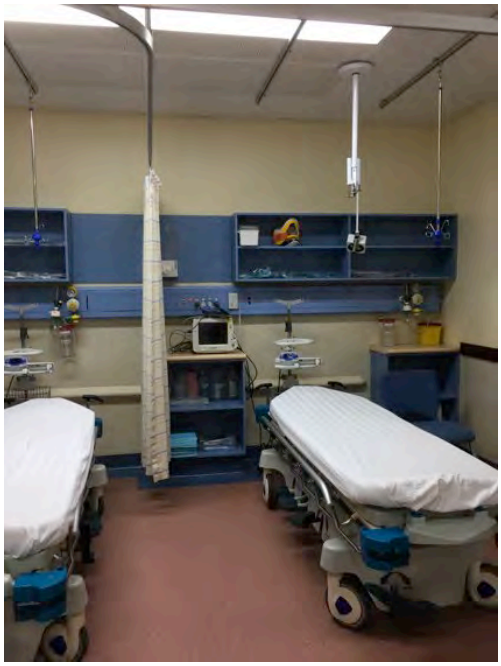


(sprinter ambulance equipped with MRX)

The emergency response/capability of PIH was assessed by visual inspection and discussion. The hospital is situated some 16 minutes from the airport and possesses two ambulances, which are used to retrieve patients. These ambulances are equipped with an MRX monitor defibrillator, suction oxygen etc. The drug resources within the ambulance are somewhat limited but it is understood that drug packs will be taken from the hospital for a patient retrieval. The vehicle is crewed by a driver, paramedic, nurse and doctor depending on the nature of the patient's condition.

The vehicles are Mercedes sprinters sourced from Victoria and still configured for paramedic use s 33(a)(iii)

Patients are sometimes bought directly to the hospital via other providers and handovers are adequate, however a local private EMS provider was quoted as needing development in this area.



(resuscitation bay)

The ED has two resuscitation beds, one procedure room and four other beds with the capacity to expand into a neighbouring room.

The department is staffed by dedicated nursing and medical staff. Mobile X-rays are possible in the department.

Triage occurs, which allows preferential treatment of the sickest. The resuscitation bay is well stocked and supported with appropriate emergency department monitors as are the other beds. There are two oxylog ventilators and drugs available for a rapid sequence induction. Airway equipment included nasopharyngeal and laryngeal mask airways as well as Endotracheal Tube (ET) tubes. There was a full range of functioning self-inflating bags for ventilation support. Pulse oximetry was readily available and both venous and arterial blood gases were available. A full range of equipment supports chest drain insertion. IV access utilises a full range of cannula, there was an absence of a rapid expander kit or an intraosseous insertion kit.

Drugs are available in the resuscitation trolley and included:

- Adrenaline
- Atropine
- Amiodarone
- Pheniramine maleate
- Frusemide
- Dexamethasone
- Adenosine
- Potassium chloride
- Calcium gluconate
- Sodium bicarbonate
- Lignocaine
- Hydrocortisone
- Propofol
- Suxamethonium

These represent an appropriate emergency resuscitation drug list.

Resuscitation is guided by AHA resuscitation guidelines. There are three Anaesthetists available to support resuscitations. The staff reported successful resuscitation of trauma patients, one with a vascular injury to the neck and an intra-abdominal injury.

The ICU is of moderate size with one single isolation room, this is not pressurised either negatively or positively. At the time of inspection there were only two patients in the ICU. Currently the clinical management of a patient in this unit is under the direction of the treating clinician with support from the Anaesthetist to assist with ventilation. An Intensivist has been engaged and is due to commence

at the hospital shortly. In the current situation this unit would be classified as a high dependency unit in Australia, and it has the ability to expand capacity following the arrival of an Intensivist. The equipment includes monitors and ventilators appropriate to adult HDU/ICU.

Surgery

There is surgical capacity with regard to equipment in order to perform a wide range of surgery including neurosurgery; however there is not currently a clinical neurosurgeon. The Neurosurgical equipment is sufficient to allow craniotomy and definitive neurosurgery. General surgery and Orthopaedics appear to be facilitated with the capacity to manage major fractures and external fixation of a fractured pelvis. There are a number of Indian specialists who have been cleared and registered allowing rapid entry should their sub specialty services be needed.

Gastrointestinal bleeding (GI bleed)

There is capacity to undertake gastroscopy procedures and to undertake interventional control of upper GI haemorrhage.

Cardiac

Cardiac care is supported by monitored beds, and there is capacity to provide thrombolysis using streptokinase, high sensitivity troponin testing, as well as performing elective angiograms and angioplasty, and cardiac echoes and stress tests. There are plans to perform hot cardiac angioplasties in the near future.

Obstetric

(neonatal resus units)

There are adequately equipped birthing suites and neonatal resuscitation facilities staffed by nurses who demonstrate an understanding of neonatal resuscitations. There is a functioning neonatal resuscitation unit suitable for standard neonatal resuscitation of term deliveries.

Dialysis

There is capacity to facilitate three dialysis patients simultaneously with one unit identified for hepatitis positive patients. Currently there is no vascular surgery capability to maintain and create Arteriovenous Fistula, which is managed through the general Hospital.

Pathology

A full range of standard blood tests is immediately available and the equipment is maintained by two dedicated biomechanical engineers who are employed full-time. Cardiac troponin testing uses high sensitivity troponin tests backed up by an ISTAT unit.

Blood bank

Elective surgery transfusions are managed by blood donation from family members with a two bay blood donation suite. Blood screening for hepatitis and HIV is undertaken, due to the high levels of HIV within the population. There is an adequate blood fridge with space for 80 units and a centrifuge for separating blood products. s 33(a)(iii)

(AFP blood fridge)

(main blood fridge)

Radiology and imaging

There is an MRI scanner and two CT scanners on site which are supported with an uninterrupted power source capable of maintaining scanning for 25 minutes to allow the completion of an examination. Two Radiologists are on staff to read the scans. X-rays and ultrasounds are available in two units. Currently interventional radiology is not offered however, one of the Radiologists has experience in this field.

Isolation rooms

There are two isolation rooms with air locks that are appropriate for managing highly infected patients in the facility.

Reserve capacity

In addition to the existing staff, the CEO has a number of Indian specialists preregistered and is able to commence work at short notice. In many respects this hospital resembles a well-equipped rural base hospital in Australia.

7.IHMS facilities at the RPC assessment

The IHMS facilities were inspected and capacity assessed by visual inspection and discussions were undertaken with staff.

Ambulances

Two vehicles exist, a troop carrier and an ex-Queensland ambulance, s 33(a)(iii) The troop carrier was equipped with a monitor defibrillator, suction, prehospital care and equipment appropriate to respond to a case. Drugs are kept in the facility because of heat issues in the vehicles. These may be loaded prior to dispatch.

(well-equipped troop carrier ambulance)

(ex-Queensland ambulance s 33(a)(iii)

s 33(a)(iii)

s 33(a)(iii)

Currently there are fire trained individuals who would have the expertise to run some extrication equipment, possibly rams and cutters which do not have to be heavy duty as there are relatively few heavy vehicles on the island.

Emergency resuscitation bays

(resuscitation bays)

Two identical resuscitation bays equipped with monitor defibrillators, oxylog ventilators and resuscitation trolleys exist. Very few patients require intubation and ventilation however this may be undertaken safely in this environment. Drugs and equipment in the resuscitation trolleys were appropriate. There are a further two monitored beds in the department allowing management of four critical patients at once.

Theatre

There is a fully equipped theatre, which is currently not operational s 33(a)(iii) Supporting theatre is a recovery bay with space for two patients. Oxygen is piped to the theatre and the recovery area but the ED runs on cylinders. There is a functioning steriliser, which is used.

Ward

There is an effective fully equipped six-bed ward, which is not licensed to be used as a ward but is suitable for inpatient management with individual rooms and en suite, etc. This could be utilised if required.

Isolation/containment unit

There is a four-bed isolation/containment unit, which might be used for patients requiring isolation as part of management s 33(a)(iii)

Behavioural disturbance/mental health emergency

s 33(a)(iii) There is an area dedicated to providing voluntary respite to patients s 33(a)(iii)

Pharmacy

There appears to be a reasonable range of pharmacy available including antibiotics for resistant organisms, such as vancomycin. s 33(a)(iii)

s 33(a)(iii)

Dental emergencies
A dentist visits on a regular basis staying for a week at a time and manages dental emergencies if required.

Eye emergencies
There is a slit lamp available for eye examination.

Radiology
Portable X-rays can be taken and are digitally reported at North Shore. The X-ray unit lacks flexibility but is capable of X-raying even large abdomens. There is no facility to undertaken contrast studies.

Ultrasound
There is a portable ultrasound machine available for use.

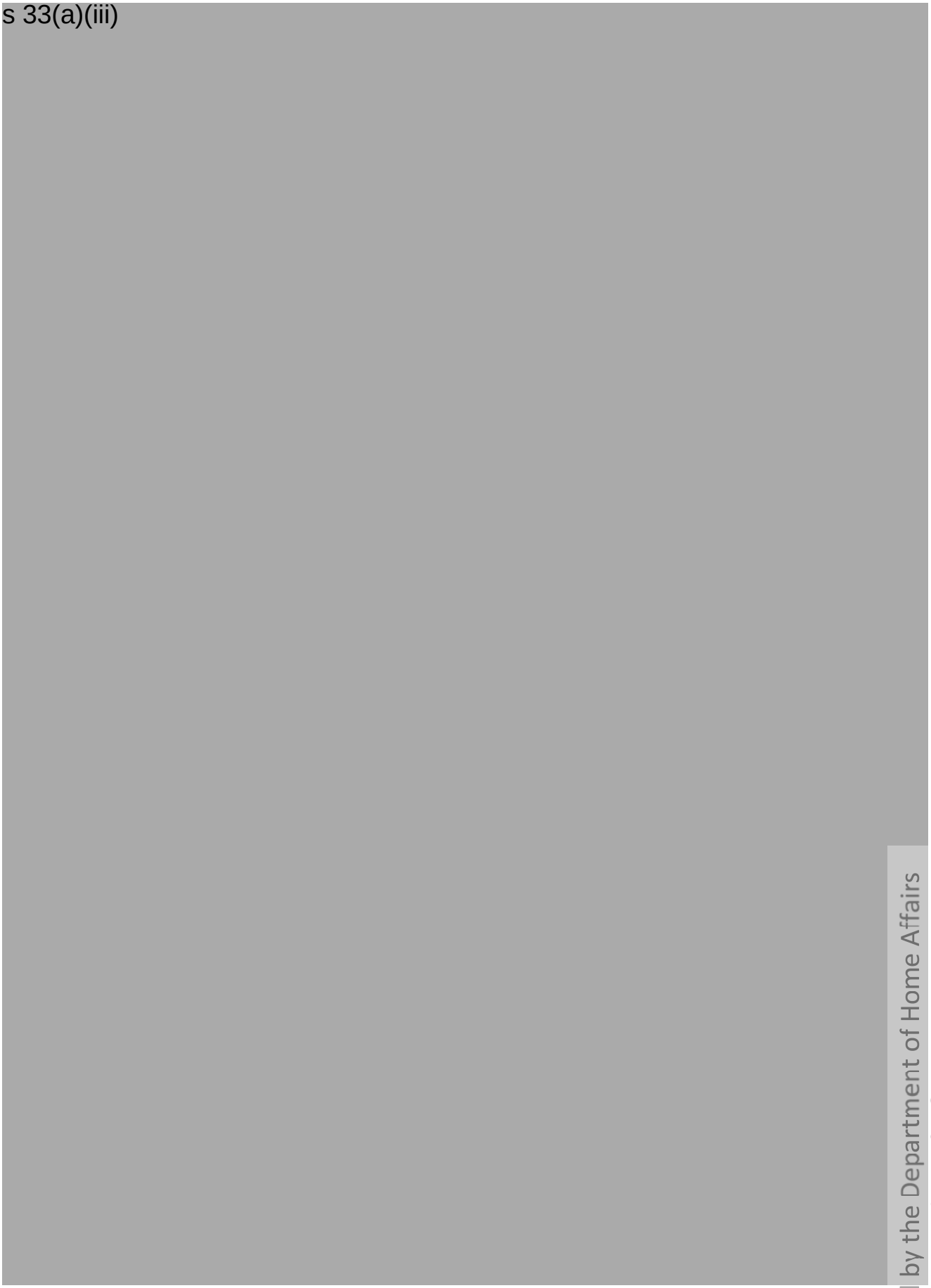
Pathology
A wide range of pathology tests may be performed using ISTAT machines as well as a number of care testing machines. s 33(a)(iii) Biochemistry, full blood count, troponin and gases are all available for testing. Malaria testing has presented positives, including staff despite antimalarial education. Vector control around the site appears to be effective. Further pathology for detailed tests may be arranged by sending samples to Australia with results being available in a couple of days.

Blood
There is a fully functional large blood fridge but unfortunately no blood. s 33(a)(iii)

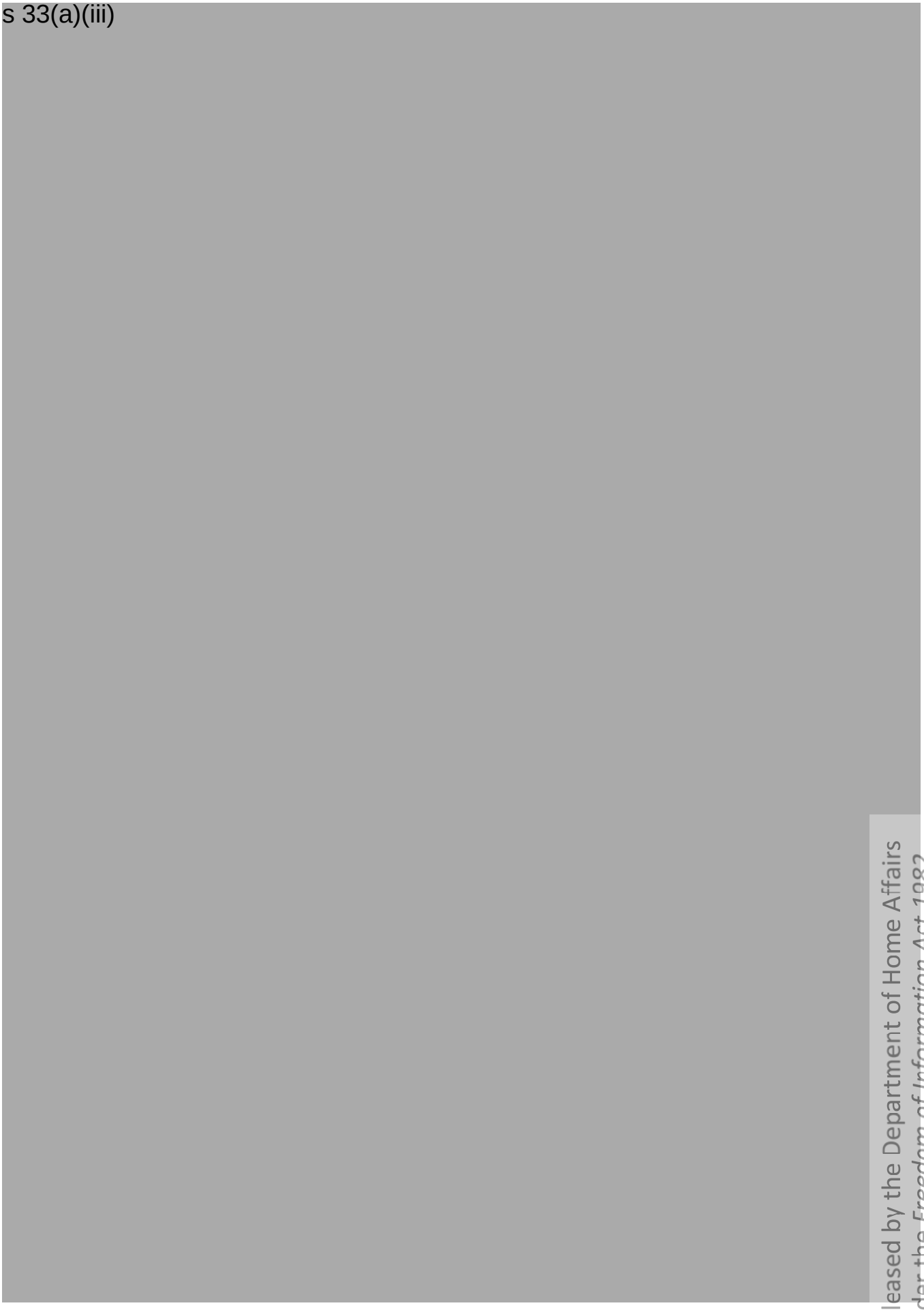
Medical evacuation
s 33(a)(iii)

Mass casualty
There are pre-boxed stores ready to respond to a mass casualty and a large amount of burn gel available. There are also empty boxes into which equipment may be loaded should the facility need to be evacuated. This has occurred once in response to a tsunami warning.

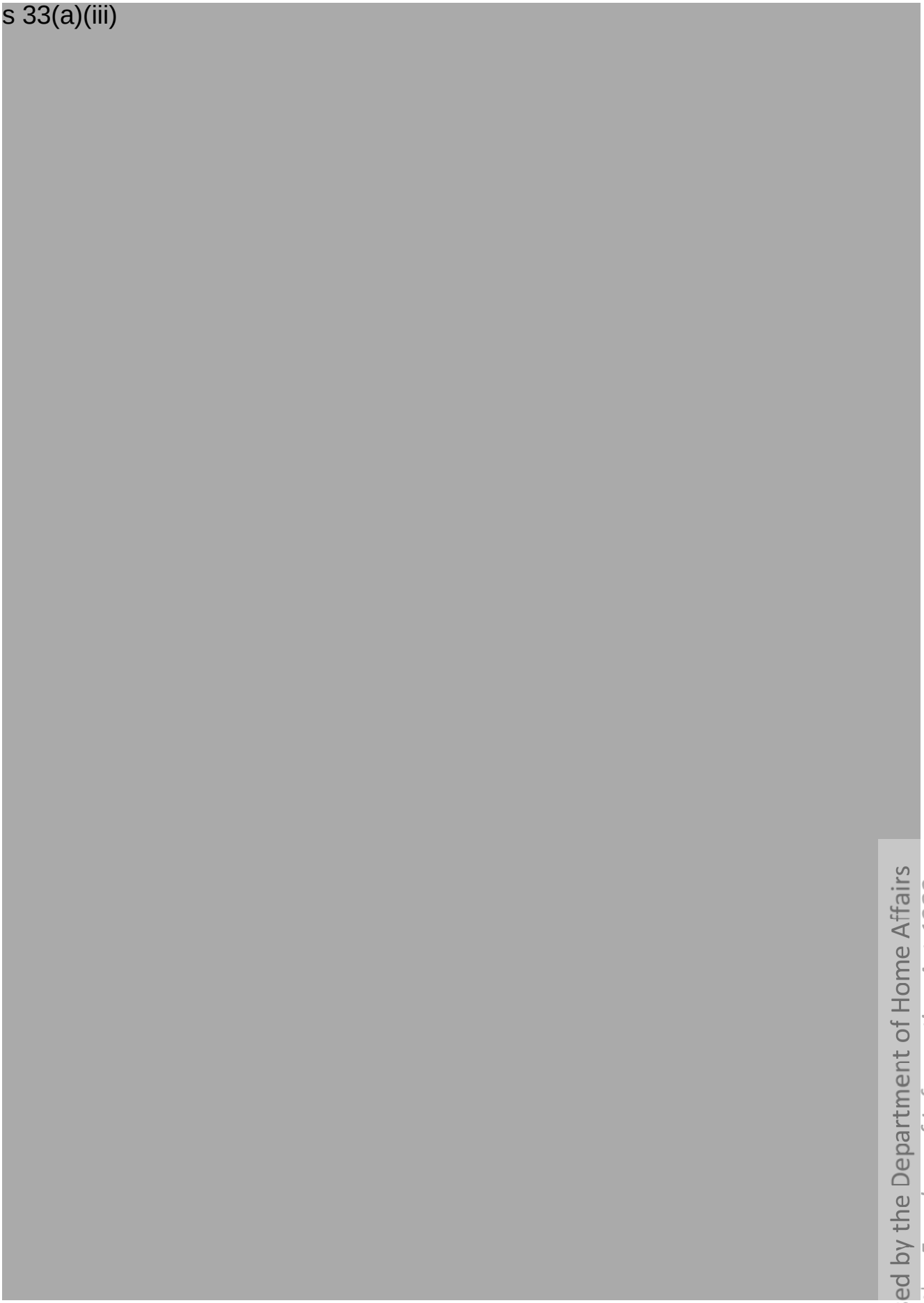
s 33(a)(iii)

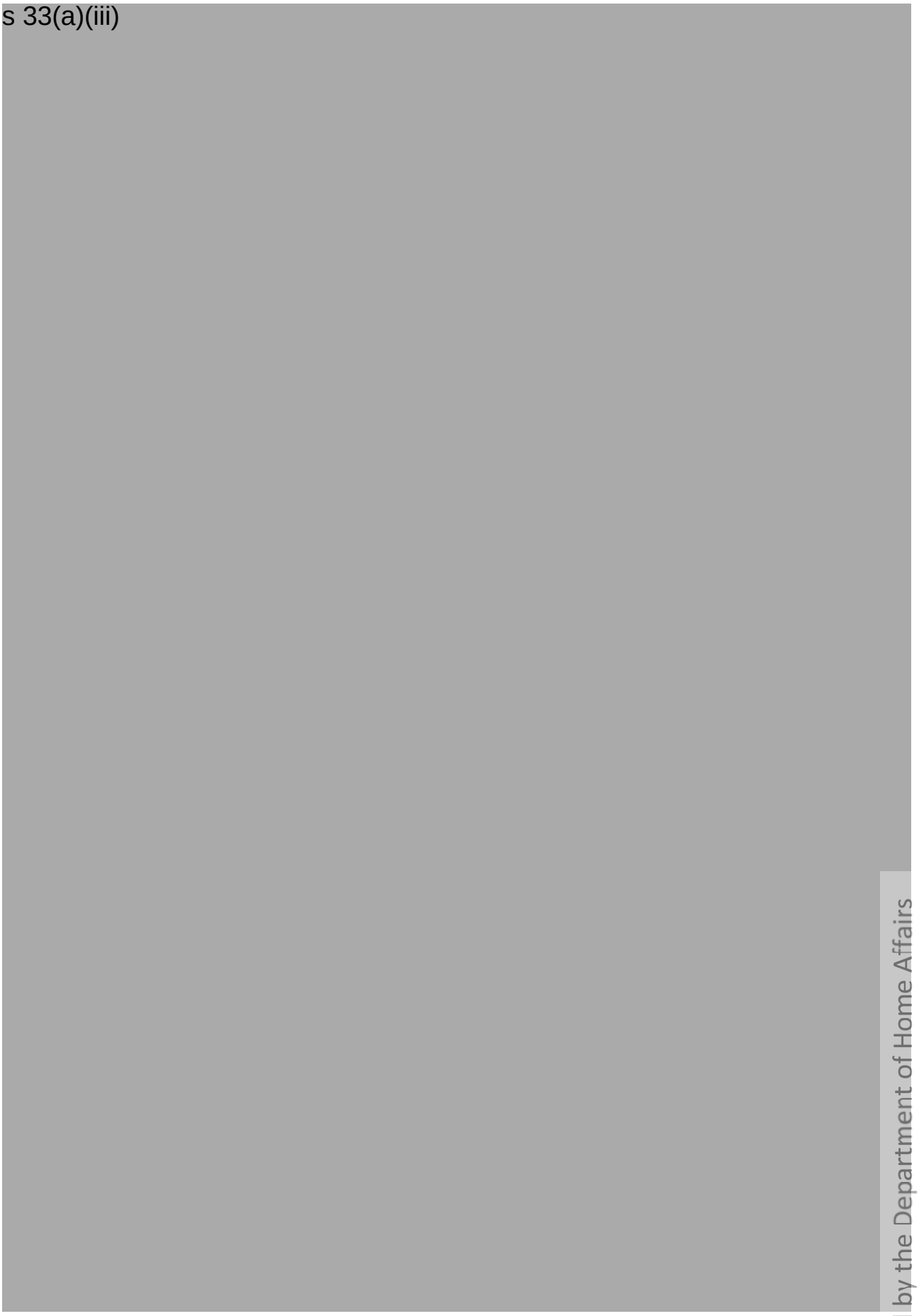


s 33(a)(iii)

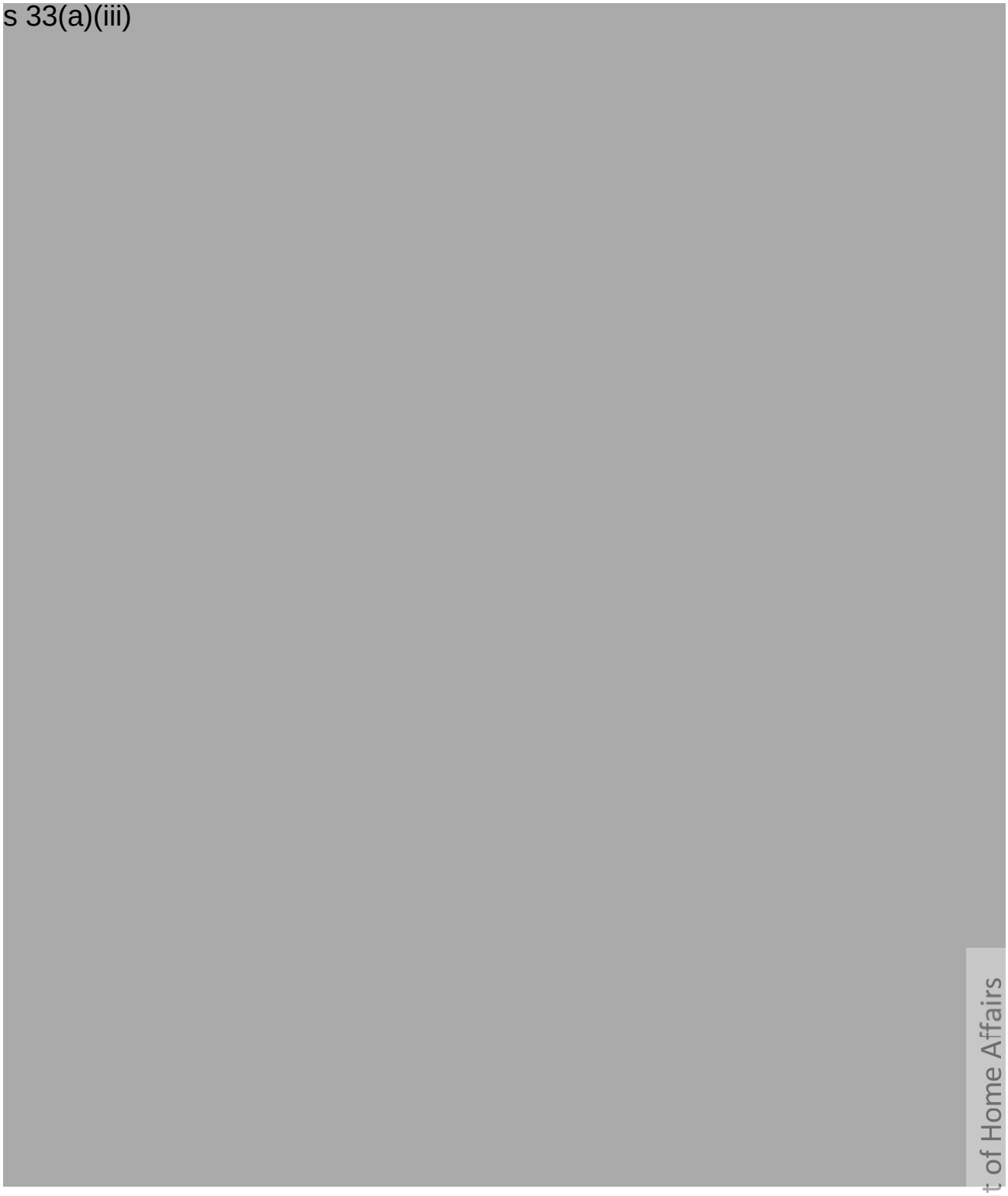


s 33(a)(iii)





s 33(a)(iii)



11. Education session at PIH

An education session focusing on recent/current discussions in emergency care was arranged for Friday morning (4 November 2016). The session was facilitate for over an hour with good interaction and questions and was attended by 24 participants including the Chief of Surgery, Anaesthetists and ICU and ED staff.

Topics discussed included:

- Chest trauma
- Pneumothorax, needle vs. finger thoracotomy
- Tamponade management
- Intra-abdominal haemorrhage
- Minimal vol resus
- Vascular access expanders and IO
- Massive transfusion
- Damage control surgery
- Temperature control in trauma
- Anaphylaxis management
- Management of rapid AF
- APO management.
- CCF and COAD management
- Tranexaemic acid and factor VII

Much of the direction of the session was determined by the participants' interest and questions.

Suggestions from participants included:

- The need for courses in ALS EMST etc., which could be facilitated in PIH with a mixed faculty.
- The possibility of exchange with Australian specialists.
- Possibility of PIH teams operating at the RPC if the theatre was operational.

All these suggestions are worthy of further consideration.

12. Contingency planning

s 33(a)(iii)

13. General strategy

Preparations to be undertaken where a surge/major incident/disaster response plan is needed which covers:

- transport of large numbers of personnel and patients
- pre-positioning of personnel and transport platforms
- pre-registration and authorisation of clinical rights to practice for designated personnel
- identification of a responding agency and governance structure

In order to ensure smooth local relations, the involvement of a local provider (PIH) as a partner in a joint response would be prudent.

Key identified medical personnel in Australia/overseas should be pre-registered by PIH as associate members of that organisation, and could then be deployed as part of a mixed team.

Deployment arrangements including employment contract, insurance, and response times need to be negotiated with these key personnel ahead of time.

A DIBP team leader/liaison coordinator should be identified to be deployed at the time of a surge capacity.

Australian/overseas personnel could be based at PIH to work with PIH staff to provide Australian tertiary standard medical care in country in normal load situations. The secondment of Australian personnel to PIH not only ensures Australian tertiary standard and modern care but also offers PIH staff an opportunity to up skill.

A surge response would commence with placing these additional staff at PIH.

If the theatre and wards have been opened, routine lists by the visiting teams of mixed personnel under a PIH banner could provide care on-site.

In a surge situation, mixed teams under a PIH/DIBP banner could be deployed to commence resuscitation and damage control surgery on site.

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Transport arrangements need to be pre-planned with retrieval aircraft pre-positioned at Port Moresby with crew and flight plans for rapid take off to meet a patient/s at the Manus airport.

Mass transport could either be via a military plane or a chartered civilian plane.

If chartering a civilian plane, seats will need to be removed and secure tie down points installed to accommodate stretcher cases. If pre-planned, this could be achieved in a matter of a couple of hours; seats mounted on aircraft tracks and can be removed quite quickly and cargos tie down points linked to the same tracks. Adequate numbers of stretchers need to be sourced from possibly the military.

14. Summary escalation strategy

Business as usual

- external experts providing definitive care at PIH and building relationships with PIH

Level one surge (increased activity or possible concern of activity)

- pre-position external experts at PIH, pre-[position retrieval aircraft at Port Moresby, check and enhance levels of consumables and blood at RPC

Level two surge (significantly increase numbers of illness or trauma presenting at RPC)

- move up surge team focusing on either stabilisation and retrieval or damage control surgery if theatre is open to RPC
- ensure PIH fully staffed to deliver tertiary level care
- pre-position DIBP team leader/liaison role in PIH
- ensure Community Support Team adequately staffed and supported to deal with extra load
- bronze commander, RPC team leader
- silver commander, DIBP team leader at PIH
- gold commander, Chief medical Officer in Australia

Mass casualty/disaster

- consider extra planes/a large plane
- consider extra teams and resources
- consider extra resources for Port Moresby Community Support Team
- ensure staff safety and security of patients and staff, liaising with Port Moresby police/military