Independent Health Advice Panel

Visit Report: Papua New Guinea

9–11 October 2019

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1. Background and scope

Section 199A(2) of the *Migration Act 1958* (the Act) outlines the objective of the Independent Health Advice Panel (IHAP) is to monitor, assess and report of the physical and mental health of transitory person who are in regional processing countries and the standard of health services provided to them.

IHAP members Associate Professor Susan Moloney and Associate Professor Neeraj Gill travelled to Port Moresby, Papua New Guinea from 9 – 11 October 2019. The IHAP members were accompanied by First Assistant Secretary, Health Services Division and Acting Director, IHAP Secretariat. This report was prepared based on the visit, and in consultation with the other members of the panel.

In order to undertake the duties prescribed under s199A of the Act, the visit included the review of the health facilities and services provided in Port Moresby. The visit itinerary included:

1. Teleconference with the Department of Home Affairs' Offshore Health Operations.

The two IHAP members were provided with a detailed overview of the Health Operations process and explain the roles of the Department, PNG's Immigration and Citizenship Authority and the relevant service providers in facilitating medical transfers.

2. Meeting with JDA Wokman

To discuss the case management and welfare service provided to transitory persons in Port Moresby.

3. Visit to Pacific International Hospital Port Moresby.

The visit included a tour of the facility and discussions with the Hospital's Chief Executive Officer, Medical Director and Psychiatric team.

4. Vehicle tour of relevant location across Port Moresby

The sites toured include:

- Granville Hotel;
- Lodge 10;
- Citi Boutique Hotel;
- Hodava Hotel;
- Shady Rest Hotel;
- Port Moresby General Hospital; and
- A number of unit complexes identified for the community placement accommodation.

5. Visit to the Vision City Clinic

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2. Observations

The Panel members were impressed with multi-disciplinary clinical services being provided at the Pacific International Hospital (PIH), POM.

- The panel members were pleased with the expertise and experience of doctors including specialists in various fields of medicine/surgery.
- Clear governance lines were in place
- The panel noted that the hospital was resourced with facilities e.g. CT and MRI scans, pathology laboratory, blood bank, cardiac stress testing, physiotherapy gym**.** These had emergency back up capabilities.
- There is a well-equipped Intensive Care Unit, Emergency department and operation theatres.
- There did not seem to be any capacity issues in any part of the hospital.
- There is a primary health clinic in a separate building next to the hospital and another primary health facility in the Vision City Mall, which is easily accessible through public transport.
- Overall, the medical/surgical facilities at the hospital were satisfactory.
- However, IHAP members observed a lack of hand-hygiene disinfectants throughout the hospital and recommend more hand-hygiene disinfectants be made available especially at the entrance and corridors of inpatient facilities.
- Access to medications:
  - There were supply chain issues at Manus, which do not seem to be a problem at Port Moresby.
  - There is a dispensary at both the PIH and the Vision City clinic. Patients are given fixed term scripts (usually monthly) and return for outpatient appointment for further prescription.
  - s33(a)(iii)

The panel members also appreciated the experience and expertise of psychiatrists (including the newly-joined psychiatrist), clinical psychologists, nurses and social worker in mental health. The panel did, however, feel that there was a significant scope for improvement in the mental health model of care and psychosocial supports available for Relevant Transitory Persons (RTP's) in PNG. The findings of IHAP and recommendations to improve the mental health/psychosocial services are as follows:

1. MODEL OF CARE: PIH psychiatric services operate on a biomedical model with limited psychosocial interventions and no clinical outreach. However, PIH advised that they have applied to the Department of Home Affairs (DHA) for an outreach team to provide assertive community mental health support.

2. Inpatient unit – The panel found the inpatient unit to have a custodial rather than therapeutic milieu.
   - Locked ward
   - s33(a)(iii)
   - It was advised that voluntary patients are not allowed to leave the ward unless accompanied by a nurse and security guard. However it was reported that patients are allowed to visit the hospital café on their own.

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- Activity room is a sterile clinical space, which is hardly used- no structured activities, no activity schedule. It was advised that a group therapy program has been commenced in the last one month.
- There is a seclusion room with padded walls with observation window and CCTV camera and attached bathroom. The bathroom is out of CCTV coverage.
- The bathroom handrails have been made temporarily ligature-proof but the water taps are not ligature-proof.
- There appear to be no current capacity issues. The bed occupancy has come down significantly and there were only five patients on 09/10/2019. The capacity is 15 beds and can flex to 18 if required, by accommodating three patients in activity room.
- We were informed that no self-harm has occurred on the unit.
- Short leave program (for a few days) has been commenced to be trial before discharge.

3. Lack of assertive community mental health/outreach service, except a social worker who, it was reported, visits Granville Hotel. PIH are currently asking Department of Home Affairs to fund a community mental health outreach team, IHAP supports this approach.

4. Torture and trauma counselling
   - Cognitive Behaviour Therapy (CBT) and relaxation exercises are offered, but there is no specialised torture and trauma counselling service. No other psychotherapies e.g. Inter-personal therapy, Acceptance and Commitment Therapy, Trauma Focused CBT were reported to us.
   - Lack of in person interpreters may interfere with effective psychotherapy
   - The focus appeared to be on symptoms rather than patient-narrative, and on diagnosis rather than a psychological formulation.

5. Lack of in-person interpreters
   - Interpreters available only through phone
   - s33(a)(iii)

6. Lack of any specific clinical practice guidelines for management of mental disorders, various international guidelines were used by clinical team members.

7. Poor communication/relationship between inpatient clinical team and welfare service
   - There has been a breakdown of relationship between PIH and JDA (welfare service). There previously was a weekly meeting, which is no longer happening.
   - Inpatient team working on a biomedical model; and welfare workers providing social/humanistic support, with no connection between these two models
   - No direct communication between inpatient medical/psychologist/nursing team and welfare case workers
   - Welfare case workers rarely see the patient on the inpatient unit.

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- Welfare case workers do not attend inpatient team meetings for their clients admitted in the inpatient psychiatric unit.
- Welfare case workers do not receive discharge summary.
- Welfare case workers reportedly find it hard to contact PIH psychiatric team if they have concerns for any of their clients in community. However, PIH advised that there was a plan for a crisis phone number to be put in place soon.

8. s33(a)(iii)

9. Resettlement Model is commencing in the community. Recent acquisition of independent hotel style accommodation where the Transitory Persons can become more independent, supported by JDA.

3. Recommendations

1. MODEL OF CARE:
   - IHAP recommend that the model of care for psychiatric services be changed to a recovery-oriented, person-centred model with assertive community mental health through an outreach team.
   - Inpatient admissions may be used as the last resort, with preferred way of engagement and treatment being in the community. The bulk of the psychiatrists'/psychologists' time may be shifted to outpatient/community mental health model.
   - The panel recommends strong partnership and integration among the inpatient team, the proposed community clinical outreach team and welfare team.

2. Inpatient unit – To change the milieu of inpatient unit to therapeutic, rather than custodial
   - The panel recommend that the psychiatric inpatient unit should be an open ward, which may be locked only if there is a high risk involuntary inpatient or a detainee under another legislation who is at high risk of absconding.
   - Deploy security guards only if a patient is assessed to be at high risk of aggression which cannot be managed through clinical and psychosocial interventions.
   - Or decrease the number of security guards.
   - Security guards, if any, should be in plain clothes
   - Voluntary patients must be allowed to leave the ward unaccompanied. Invoke PNG Mental Health Act 2015 only if a patient is to be restricted to the ward, if criteria for involuntary treatment are met.
   - Structured individual and group activities as per an activity schedule

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3. Assertive community mental health outreach service by recruiting 5-6 community mental health clinicians at PIH

4. Torture and trauma counselling
   - Provide specialised torture and trauma counselling services.
   - Consider peer support/supervision by psychologists experienced in torture and trauma counselling

5. Contract in-person interpreters
   - Interpretation, especially for psychotherapy, is better through in-person interpreters than on phone
   - Interpreters can also act as cultural advisors

6. Follow specific clinical practice guidelines for management of mental disorders including bio-psycho-social-lifestyle interventions and trauma-informed care.

7. Communication and relationship between inpatient clinical team and welfare service
   - Put in place protocols to ensure direct communication between PIH medical/psychologist/nursing team and JDA welfare case workers
   - Welfare agency to advise PIH of clear roles and responsibilities of case workers
   - Welfare case workers to visit their admitted clients in the inpatient unit, with patient's consent
   - Welfare case workers to attend inpatient team meetings for their admitted client, with patient's consent
   - Welfare case workers/agency to receive discharge summaries, with patient's consent.
   - Welfare case workers to be provided with direct contact number for PIH psychiatric team, to be able to contact if they have concern for any of their clients in community

8. Robust clinical governance framework, including but not limited to:
   - Seclusion and restraint, if any, must be documented and regularly audited.
   - Reflective practices e.g. multi-disciplinary incident review after any adverse event e.g. self-harm or aggression/assault on the ward.
   - Medication audit including documentation of reasons for changes in medications.

9. Recommend Key Performance Indicators e.g:
   - Post-Discharge Clinical Outreach Follow up within 3-5 days
   - Regular follow up of all community clients
   - Regular MDT's between PIH and JDA

In summary, the panel recommend transitioning the model of care from a custodial and biomedical model to a recovery-oriented, person-centred, assertive community treatment model which respects the dignity of transitory persons with mental health issues and promotes their recovery and reintegration into the community.

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