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EVALUATION OF THE PSYCHOLOGICAL SUPPORT PROGRAM (PSP) IMPLEMENTATION

Prepared for the Department of Immigration and Citizenship

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List of Acronyms

ACCT	Care in Custody and Teamwork
APOD	Alternative Place of Detention
ARMS	At-Risk Management System
DAL	Darwin Airport Lodge
DeHAG	Detention Health Advisory Group
DIAC	Department of Immigration and Citizenship
DSP	Detention Service Provider
HSM	Health Service Manager
IDC	Immigration Detention Centre
IDFs	Immigration Detention Facilities
IHMS	International Health and Medical Services Pty Ltd
IMA	Irregular Marine Arrival
LWB	Life Without Barriers
MHSG	Mental Health Sub-group
NIDC	Northern Immigration Detention Centre
NTAS	Nurse Triage and Advice Service
PSO	Prison Service Order
PSP	Psychological Support Officer
SASH	Suicide and Self-Harm
SAMS	Support and Monitoring System

CONTENTS

1. EXECUTIVE SUMMARY

The Department of Immigration and Citizenship (DIAC), commissioned Ipsos Social Research Institute to conduct the Evaluation of the Implementation of the Psychological Support Program (PSP) in Immigration Detention Facilities (IDFs).

Psychological Support Officer (PSP)

Following the transition to both a new Health Services Contract and new Detention Service Provider (DSP) arrangements, the then Detention Health Services Branch coordinated a phased implementation of the PSP policy, including the delivery of training, throughout the immigration detention network between February and November 2010.

The aims of the PSP are twofold:

- Firstly, to provide a clinically sound approach for the identification and support of people in immigration detention who are at-risk of self-harm and suicide; and
- Secondly, to reduce of the level of uncertainty for staff in dealing with clients at-risk by establishing clear procedures for staff, and by giving staff the specific skills needed to be able to manage situations that may arise.

The PSP is implemented by all staff who have contact with, or who advocate for, persons in immigration detention, regardless of detention placement.

Since the implementation of the PSP, there have been several deaths and an increase in the rate of self-harm in IDFs. As a result of this, the Detention Health Advisory Group (DeHAG) recommended that an independent evaluation of the implementation of PSP be undertaken. Several independent organisations (including the Commonwealth Ombudsman's office and the Australian Human Rights Commission) have also criticised the inconsistent implementation of the PSP within IDFs[1].

[1] Department of Immigration and Citizenship, 2011, Evaluation brief: Evaluation of the Psychological Support Program (PSP) implementation. Unpublished

Since the introduction of the PSP the detention environment has changed. The number of people detained in IDFs has increased (from 3,987 in October 2011 to 4,934 in June 2012) largely due to an increase in the number of irregular marine arrivals (IMAs) and the rate at which visas are granted. In 2012, the number of IMAs doubled from a total of 4,793 in 2011 to 4,788 for the first six months of 2012. The rate of granting bridging visas increased dramatically from 107 in 2011 to 2,507 in first six months of 2012 (with 622 bridging visas being granted to IMAs in June 2012 alone). However, this was not sufficient to off-set the rate of increase in arrivals of IMAs or the decline in the number of protection visas granted. Protection visas granted fell from an average of 477 per month in 2011 to an average of 308 per month for the first six months of 2012. The number of IMAs removed from Australia has been less than 100 per year for the last three years[2].

Evaluation objectives

The aim of this research was to evaluate the implementation of the PSP for the prevention of self-harm in IDFs, specifically:

- whether the PSP is sufficiently robust for the mental health challenges posed by immigration detention; and
- how well the PSP has been implemented.

The main focus of the evaluation was on the implementation of the PSP and the governance, structures and systems that support this implementation and ongoing management of the program.

Evaluation methods

The evaluation method included a mixed design consisting of:

- **An inception stage**: Prior to commencing the evaluation, the Ipsos and DIAC teams meet several times to discuss the approach to the evaluation, materials and support available to the evaluation, stakeholders contact details, IDFs to be visited and timing of deliverables. This initial information was used to develop the evaluation plan.
- **A review of documents**: DIAC provided 81 documents to the evaluation. The program documents were reviewed to provide an understanding of the program theory and key design features. These included policy documents related to PSP and health management in IDFs more generally, reports on self-harm in IDFs, PSP training materials and other background materials.

[2] Department of Immigration and Citizenship, 2012, *IMA Key Operational Statistics*, June 2012. Unpublished

- **A review of data**: DIAC also provided a data file of reported incidents of self-harm across all IDFs from October 2009 to March 2012. The data was reviewed to identify any potential outcomes since the implementation of the PSP. The data included 3,831 reported incidents and included variables relevant to the incident, the environment and the individual. This data was used to examine the pattern of self-harming reported over the time period and factors associated with changes.

- **A brief literature and model review**: Using the documents provided by DIAC as well as those from additional searches, a review of literature was conducted to establish the need for the program, its policy connections and best practice principles in harm minimization in detention settings. This review briefly examined other models of reducing self-harm in custodial environments in Australia and overseas. The models selected for this review were: Suicide and Self-Harm (SASH) Prevention and the corrective services models used in New South Wales, Western Australia and the United Kingdom. The models review considered the program development, delivery methods, program content, training standards, assessment, outcome measurements, and impact on client outcomes, subject to the availability of evidence.

- **Stakeholder interviews**: A total of 30 stakeholders from eight organisations were consulted as part of the evaluation, including both government and non-government stakeholders. (A further 79 staff were interviewed as part of the site visits).

- **Site visits**: Site visits were conducted in March 2012 to Villawood Immigration Detention Centre (IDC), Northern Immigration Detention Centre (NIDC), Darwin Airport Lodge (DAL) Alternative Place of Detention (APOD) (1, 2 and 3), and Wickham Point IDC. As part of the site visits, interviews and mini-group consultations were conducted with service providers (management and staff), DIAC (management and case workers) and other stakeholders in the detention network. Site visits explored awareness and understanding of the PSP, implementation of the PSP on site, training, communication between agencies, and perceived outcomes of the PSP.

- **An online survey of staff**: A confidential online survey of staff was conducted across six weeks in April and May, 2012. The online survey explored questions of staff awareness of the PSP, engagement in implementation, access to training, attitudes and confidence working with clients at-risk of self-harm. A total of n=392 responses were received to the online survey.

Recommendations

Based on the evidence collected during this evaluation the following recommendations are made:

Recommendation 1: High imminent supportive monitoring engagement plans should be reviewed at least every 24 hours (more often where practical) rather than every 12 hours, to

better reflect the operating environment and needs of clients (eg, a client assessed at 4pm currently requires reassessment by 4am).

Recommendation 2: The description of the three levels of supportive monitoring and engagement should be reviewed with clinicians to develop thresholds to delineating each level so that clinicians have more autonomy to tailor supportive monitoring and engagement plans to their client's needs. While this is the intent of the current PSP policy, the rigid description of each supportive monitoring and engagement level does not encourage adaptation to clients' individual needs.

Recommendation 3: The supportive monitoring and engagement plan should be separated into two components (monitoring and engagement) and clearly specific how Serco staff are to engage with the clients, beyond monitoring alone. The current approach encourages observation rather than engagement by Serco staff. This model would also encourage improved communication between IHMS and Serco operational staff in developing and implementing engagement plans.

Recommendation 4: IDF staff should have access to nationally consistent initial and ongoing competency-based training on the PSP that is relevant to their engagement with clients. Such training should include clear learning objectives and evaluate training outcomes.

Recommendation 5: The preventative focus of the PSP needs to be strengthened. This may include a range of activities such as improved cultural awareness, showcasing best practices in prevention from each IDF, improving the integration of IHMS mental health teams into the IDF environment (which may include mental health outreach service models) or increased engagement of clients in meaningful activity.

Recommendation 6: IHMS, Serco and DIAC should develop a joint communication strategy for sharing information about clients at-risk of self-harm. This strategy should also document internal agency communication strategies. All staff working with a client assessed as at-risk should have access to a common agreed level of information about the client to manage that risk.

Recommendation 7: Where a client is identified as at ongoing risk of self-harm, through an underlying aetiology or history of behaviour, an extended case management procedure should be available to coordinate their ongoing support across agencies to reduce their future risk.

Recommendation 8: The PSP procedures should be amended to allow IHMS staff the option of consenting clients to share mental health information with other agencies involved in their care, for the purpose of better management of their risk of self-harm and preventative engagement.

Recommendation 9: The after-hour's arrangements in the PSP policy documents should be clarified so that the policy communicates more clearly the 24-hour referral, assessment and protective care pathways for clients identified as at-risk when a clinician is not available.

Recommendation 10: A nationally consistent strategy needs to be developed to guide the implementation and monitoring of the PSP. This national strategy should include clear targets to measure the performance of the PSP. These targets should be incorporated into contract management systems.

Recommendation 11: The quality of data reporting needs to be improved through the development of agreed data definitions and pilot testing of the reliability and validity of reporting to develop a robust measurement system. Data reporting should have clear links to performance monitoring and quality improvement systems within a monitoring and evaluation strategy.

2

This section provides a background to self-harm and suicide prevention and introduction to the policy environment

2. BACKGROUND

The following section provides an overview of the self-harm and suicide prevention in society and Australian IDFs.

2.1 Self-harm and suicide prevention

There is no universal definition of self-harm. Generally it is agreed that self-harm covers a range of acts, occurs for a multitude of reasons, and in a range of setting. These acts vary in their levels of intensive and include thoughts, threats, behaviours and omissions relating to intentionally harming oneself or suicide[3].

A suicide occurs when a person deliberately undertakes an act with the intention of ending his or her life. Suicide is not necessarily linked to self-harm but self-harming can itself be a risk factor for attempted and completed suicide[4].

Australia's national approach to suicide prevention is contained in the Living is for Everyone (LIFE) Framework. This framework was developed in 2007 (the latest in a series of national suicide prevention initiatives in Australia that began in the mid 1990s[5]) to provide a national framework to guide population health approaches and prevention activities.

The LIFE framework supports the implementation of activities and services across the community that address the needs of the broader population, of specific groups identified as being at-risk, and people who may be at high risk of suicide (defined as universal, selective and indicated

[3] Royal College of Psychiatrists, 2010, *Self-harm, suicide and risk: helping people who self-harm*. Available at: http://www.rcpsych.ac.uk/. Accessed: 19/04/2012.
[4] The Senate, 2010, *The Hidden Toll: Suicide in Australia*, p.26. Available at: www.lifeline.org.au. Accessed: 19/04/2012. Australian Government, Canberra.
[5] Department of Health and Ageing, 2007, *The Living is For Everyone (LIFE) resources*, p.3. Available at: http://www.livingisforeveryone.com.au. Accessed: 17/05/2012. Australian Government, Canberra.

interventions). The framework is informed by: risk and protective behaviours, resilience and vulnerability, the impact of the interaction of personal factors and life events (including mental health) and warning signs and tipping points[6].

The LIFE framework identifies a number of crucial elements in delivering suicide prevention activities:

- that they target everyone in the community (universal intervention), groups potentially at-risk (selective intervention) and individuals at high risk of suicide (indicated intervention)[7];
- activities must be appropriate to the social and cultural needs of the groups or populations being served;
- information, service and support needs to be provided at the right time, when it can best be received, understood and applied;
- activities need to be located at places and in environments where the people most at-risk are comfortable, and the activities are accessible to those who most need them; and
- local suicide prevention activities must be sustainable to ensure continuity and consistency of services[8].

2.1.1 Risk and protective factors

Although understanding the causes of self-harm is often important for clinical assessment and determining the appropriate treatment plan, such behaviour is often a multi-determined and not the consequence of a single issue. There are a number of risk factors (or vulnerabilities) which may increase the likelihood of self-harm and suicide, and protective factors which may improve a person's ability to cope with difficult circumstances and enhance their resilience (Table 1).

[6] Department of Health and Ageing, *Research and evidence in suicide prevention,*,p.24. Available at: http://www.livingisforeveryone.com.au. Accessed 18/05/2012. Australian Government, Canberra.
[7] Department of Health and Ageing, 2007, *Fact sheet 11, Types of suicide prevention activities.* Available at: http://www.livingisforeveryone.com.au. Accessed 18/05/2012. Australian Government, Canberra.
[8] Department of Health and Ageing, 2007, *Fact sheet 10, Principles for conducting suicide prevention activities.* Available at: http://www.livingisforeveryone.com.au. Accessed 18/05/2012. Australian Government, Canberra.

Table 1: Risk and protective factors

Level	Risk factors	Protective factors
Individual	Gender (male), mental illness or disorder, chronic pain or illness, immobility, alcohol and other drug problems, low self-esteem, little sense of control over life circumstances, lack of meaning and purpose in life, poor coping skills, hopelessness and guilt and shame;	Gender (female), mental health and wellbeing, good physical health, physical ability to move about freely, no alcohol or other drug problems, positive sense of self, sense of control over life's circumstances, sense of meaning and purpose in life, good coping skills, positive outlook and attitude to life and absence of guilt and shame;
Social	Abuse and violence, family dispute, separation and loss, peer rejection, social isolation, imprisonment, poor communication skills, and family history of suicide or mental illness;	Social physical and emotional security, family harmony, supportive and caring parents/family, supportive social relationships, sense of social connection, sense of self-determination, good communication skills and no family history of suicide or mental illness;
Contextual	Contextual neighbourhood violence and crime, poverty, unemployment, economic insecurity, homelessness, school failure, social or cultural discrimination, exposure to environmental stressors, lack of support services[9].	Contextual safe and secure living environment, financial security, employment, safe and affordable housing, positive education experience, fair and tolerant community, little exposure to environmental issues and access to supportive services[10].

These risks and protective factors apply to persons in immigration detention. Additional risks may also exist for immigration detention clients due to factors such as experiences of war and trauma, relocation from the familiarity of the home country, and lost their family friends. These factors are associated with post-traumatic stress disorder or depression which is a known risk factors for self-harm and suicide. In addition, recovery may be hampered by a lack of social supports (such as family and friends[11]) which might typically be available to those out in the community.

[9] Department of Health and Ageing, 2007, *Living is for Everyone (LIFE) – Research and evidence in suicide prevention,* p.14. Available at: http://www.livingisforeveryone.com.au. Accessed: 17/05/2012. Australian Government, Canberra.
[10] Ibid.

[11] UQ Group for Suicide Prevention Studies, 2011, *Seeking solutions to self-injury – A guide for school staff*. p.4. Available at: http://www.suicidepreventionstudies.org. Accessed 19/04/2012. Centre for Clinical Neuroscience and Psychiatry, The University of Queensland.

In view of the pre-existing vulnerabilities and factors associated with the immigration detention environment, the PSP identifies a number of risk factors which may be more common for persons in immigration detention, including:

- 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[12].

There is also a link between the length of time in detention and increased risk of self-harm and suicide, and poor mental health outcomes generally[13]. The Australian Human Rights Commission has continued to raise concerns regarding the impacts of prolonged and indefinite detention on people's mental health[14].

Recognising and identifying signs of self-harming behaviour and suicidal intent is extremely complex particularly as these behaviours may often be kept secret. In the community, it is however possible to identify some warning signs. These general signs include:

- **Psychological signs:** dramatic changes in mood (especially in adolescence, or in adults with previous history of self-harm), changes in usual eating and sleeping patterns, losing interest in friends and social activities, breakdown in regular communications with family or friends, hiding clothes or washing, lack of interest in favourite things or activities, problems with relationships, low self-esteem, being secretive about feelings, strange excuses for injuries, dramatic drop in performance and interactions and withdrawing from usual life.

[12] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*, p.5. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.
[13] Green, J. & Eager, K., 2009, *The health of people in Australian immigration detention centres,* eMHA Rapid Online Publication 14 December 2009. Available at: www.mja.com.au. Accessed: 19/04/2012.
[14] Australian Human Rights Commission, 2011, *Immigration detention at Curtin,* p.31. Available at: http://humanrights.gov.au/. Accessed: 19/04/2012

- **Physical signs:** unexplained injuries (such as scratches or burn marks), unexplained recurrent medical complaints such as stomach pains and headaches, pulling hair or picking at fingers or skin when upset or distressed, hiding objects (such as matches, tablets, razors) in unusual places (such as back of drawers, under the bed, in back of cupboard) and use of drugs[15].

The PSP identifies a number of warning signs for people at-risk in immigration detention, including:

- 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[16].

2.1.2 Triggers

The threshold and trigger model suggests that the potential for self-harm exists at a certain threshold level in many people. The threshold is determined by factors such as genetic predisposition, biochemical factors in a person's metabolism, personality traits, the emotional state of hopelessness, and the presence of ongoing support systems[17]. The point at which protective factors are out-weighted by risk factors, resulting in the potential for self-harm in the face of a precipitating event, is called a tipping point. Examples of events and circumstances that may act as a tipping point include:

- an argument with a loved one or significant person;
- the breakdown of a relationship;

[15] The Royal Australian & New Zealand College of Psychiatrists, 2009, *Self-harm – Australian treatment guide for consumers and carers*, p. 5. Available at: http://www.ranzcp.org/. Accessed: 19/04/2012.
[16] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*, p.5. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.
[17] International Association for Suicide Prevention, *IASP Guidelines for Suicide Prevention*. Available at: http://www.iasp.info/suicide_guidelines.php. Accessed: 19/04/2012.

- the suicide of a family member, friend or public role model;
- a media report about suicide;
- the onset or recurrence of a mental or physical illness;
- unexpected changes in life circumstances; and
- experiencing traumatic life events, such as abuse, bullying or violence[18].

In view of these triggers, the PSP incorporates triggered re-screening. Re-screening is automatic and absolute under a number of circumstances, for example, if there is a negative visa outcome (primary or appeal), harm to self or others in the environment, and media attention related to self-harm, negatives decisions and other events. In other circumstances, for example if a client presents with signs of changes in behaviour, clinical judgement is used to determine whether the clients' risk status needs to be re-evaluated[19].

2.2 Immigration detention in Australia

Australia's Migration Act 1958 requires detainment of people who are not Australian citizens and who do not have a valid visa giving them permission to be in Australia. These are usually people who have arrived in Australia without a visa, overstayed their visa or had their visa cancelled. Immigration detention serves an administrative purpose where people who do not have a valid visa are detained while their claim to stay in Australia is considered or their removal is facilitated[20]. Over the years, a range of IDFs have been established across Australia including Detention Centres, Residential Housing, Transit Accommodation and Alternative Places of Detention. These IDFs aim to offer living arrangements that are appropriate to individual needs of clients.

As at 30 November 2011, there were 4,409 people in IDFs and alternative places of detention, including 3,644 men and 324 women[21]. Consistent with government policy, no children were detained in an IDC at this time. There were, however, 441 children (aged under 18 years) in other IDFs and alternative places of detention[22].

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[18] Department of Health and Ageing, 2007, *Living is for Everyone (LIFE) – Research and evidence in suicide prevention,* p.22. Available at: http://www.livingisforeveryone.com.au. Accessed: 17/05/2012. Australian Government, Canberra.
[19] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*, p.13. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.
[20] Department of Immigration and Citizenship, *Background to Immigration Detention*. Available at: http://www.immi.gov.au/. Accessed: 06/01/2012. Australian Government, Canberra.
[21] Department of Immigration and Citizenship, *Immigration Detention Statistics Summary 30 November 2011*. Available at: http://www.immi.gov.au/. Accessed: 06/01/2012. Australian Government, Canberra.
[22] ibid

2.3 Self-harm and suicide in immigration detention

Under international human rights standards, all people have a right to the highest attainable standard of physical and mental health. Each person in detention is entitled to medical care and treatment provided in a culturally appropriate manner and to a standard which is commensurate with that provided in the general community[23]. This should include preventive and curative medical care and treatment including dental, ophthalmological and mental health care[24].

In 2009, Serco Pty Ltd (Serco), an international service company, was contracted as Detention Service Provider (DSP) by the Department of Immigration and Citizenship (DIAC) to provide services to people in immigration detention centres, residential housing and transit accommodation throughout Australia. DIAC also contracted International Health and Medical Services Pty Ltd (IHMS) as Health Service Manager (HSM) in 2009 to provide general and mental health services to people in immigration detention. Together with DIAC, these service providers have a shared responsibility to uphold the humane principles and standards required to ensure adequate care and security of people in immigration.

Supporting this structure, the Detention Health Advisory Group (DeHAG) has a major role in providing DIAC with independent, expert advice regarding the design, implementation and monitoring of improvements to detention health care policy and procedures[25]. The DeHAG consists of key health and mental health professional and consumer group organisations, including the Mental Health Sub-group (MHSG), which was formed in March 2007 to focus on a range of mental health issues in the immigration detention context. At this time, for clients considered to be at-risk of self-harm or suicide, staff members were required to follow the 'Suicide and Self-harm' (SASH) protocol. The SASH protocol provided a monitoring mechanism for people at-risk[26].

A review of the SASH protocol, conducted by Monash University in 2008 found the protocol to be inappropriate and recommended that changes be made to the management of individuals at-risk of self-harm[27]. MHSG was tasked to provide advice to DIAC on the development of appropriate policy, tools and protocols. This led to the development of the Psychological Support Program (PSP, the program) and changes to the mental health screening policies including screening for survivors of torture and trauma, and mental health screening for all people in immigration detention[28].

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[23] Australian Human Rights Commission, *2011 Immigration detention in Leonora.* Available at: http://www.hreoc.gov.au/. Accessed 06/01/2012.
[24] ibid
[25] ibid
[26] Department of Immigration and Citizenship, *Detention Health Advisory Group (DeHAG)*. Available at: http://www.immi.gov.au/. Accessed: 06/01/2012. Australian Government, Canberra.
[27] Detention Health Advisory Group, *Submission to the Joint Select Committee on Australia's Immigration Detention Network from Detention Health Advisory Group, August 2011*. Available at: http://www.aph.gov.au/. Accessed: 06/01/2012.
[28] ibid

These policies were developed with reference to the Department of Health and Ageing's National Mental Health Policy to reflect best-practice approaches for identifying and supporting survivors of torture and trauma and for preventing self-harm in immigration detention[29]. The policies aim to minimise factors leading to the deterioration of mental health, and ensure that people are better equipped for life once their period of immigration detention ends, through processes such as:

- Early assessment
- Prompt referral for appropriate treatment
- Promotion of activities and programs aimed at keeping people active and engaged.

DIAC introduced these policies to detention staff and other key stakeholders between February and August in 2010. During this time, training was provided to approximately 1,200 personnel from seven different government and non-government organisations that have extensive contact with people in immigration detention including DIAC, Serco and IHMS[30].

2.4 Psychological Support Program

The PSP addresses self-harm in detention and its prevention. The program offers psychological support for people at-risk of self-harm, thereby aiming to reduce risk and improve health outcomes[31].

For people who are detained in IDFs the impact on their general and mental health can be significant. Clients are likely, by the nature of their various situations, to be at much greater risk of self-harm than the general community. Therefore, those responsible for clients owe a greater than normal duty of care regarding their health and well being[32]. People who arrive by boat (irregular maritime arrivals - IMAs) are more likely than other arrivals to have suffered torture and trauma, and experience mental health problems, including self-harm or suicide[33]. The PSP was developed to facilitate the prevention of self-harm in detention facilities and to offer psychological support for clients at-risk of self-harm. Suicide and self-harming behaviour is defined in the Detention

[29] Department of Immigration and Citizenship, 2011, *RFP For the provision of services to conduct an evaluation of the Psychological Support Program (PSP) implementation*. p.1. Australian Government, Canberra. Unpublished.
[30] Department of Immigration and Citizenship, 2010, *Annual Report 2009-10*. p.185. Available at: http://www.immi.gov.au/. Accessed 14/06/2012. Australian Government, Canberra.
[31] Department of Immigration and Citizenship, 2009, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*, p.3. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.
[32] Ibid, p.4.
[33] Department of Immigration and Citizenship, 2010, *Annual Report 2009-10*. p.185. Available at: http://www.immi.gov.au/. Accessed: 14/06/2012. Australian Government, Canberra.

Services Manual, as 'actions or threats of actions which, if carried out, may lead to self-injury or death'[34].

The aims of the PSP are twofold:

> Firstly, to provide a clinically sound approach for the identification and support of people in immigration detention who are at-risk of self-harm and suicide; and
>
> Secondly, to reduce the level of uncertainty for staff in dealing with clients at-risk by establishing clear procedures for staff to put in place, and by giving staff the specific skills needed to be able to manage situations that may arise. The PSP is implemented by all staff who have contact with, or who advocate for, persons in immigration detention, regardless of detention placement[35].

2.5 Need for evaluation

Detention services for people in immigration detention are subject to parliamentary scrutiny and accountability. Immigration detention is one of the most closely scrutinised of Government programs and both the Commonwealth Ombudsman and Parliament are advised every six months on the status of people who have been in immigration detention for two years or more. There is also regular scrutiny by external agencies, such as the Australian Human Rights Commission[36].

A submission to the Committee from the Australian Human Rights Commission in August 2011 outlines the Commission's concerns regarding the high rates of self-harm and the level of suicide across the detention network over the past year[37]. More specifically, according to information provided by DIAC to the Ombudsman's office, more than 1,100 incidents of threatened or actual self-harm across all places of detention were reported in 2010-11, while 54 incidents of self-harm were reported during the first week of July 2011 alone[38]. Furthermore, six men died in Australia's immigration detention facilities in 2010 to 2011. This includes five suicides. There have also been a significant number of reported suicide attempts across the detention network[39].

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[34] NSW State Coroner, Magistrate M Jerra, *Coronial Inquest into deaths at Villawood Detention Centre in 2010*, Available at http://www.lawlink.nsw.gov.au/. Accessed: 06/01/2012.
[35] Department of Immigration and Citizenship, 2011, *RFP For the provision of services to conduct an evaluation of the Psychological Support Program (PSP) implementation*. p.4. Australian Government, Canberra. Unpublished.
[36] Ibid.
[37] Australian Human Rights Commission, *Australian Human Rights Commission Submission to the Joint Select Committee on Australia's Immigration Detention Network.* Available at: http://www.hreoc.gov.au/. Accessed: 06/01/2012.
[38] Suicide Prevention Australia, *Submission to the Joint Select Committee on Australia's Immigration Detention Network from Suicide Prevention Australia (SPA)*, p.35. Available at: http://www.suicidepreventionaust.org/. Accessed: 06/01/2012.
[39] Australian Human Rights Commission, *2011 Immigration detention at Villawood. Summary of observations from visit to immigration detention facilities at Villawood.* Statistics provided to the Commission by the

Given the high rate of self-harm that was occurring in immigration detention at the time, the Commission was concerned that the PSP may not have been implemented across the detention network to the extent that it needed to be. During a number of detention visits the Commission heard that many staff members had not received PSP training. The Commission argued the need for a national framework for the periodic delivery of PSP training to ensure that all relevant Serco, DIAC and IHMS staff are provided with initial and then follow up training[40].

In December 2011, the NSW Coroner, Magistrate Jerram's recommendations were delivered following the inquest into deaths of three men being detained at Sydney's Villawood Immigration Detention Centre in 2010. Consistent with earlier recommendations to DIAC, the Coroner emphasized a need for:

- increased collaboration between DIAC, Serco and IHMS to ensure a consistent set of procedures are established to deal with mental health related issues;
- a standard procedure and/or tool for assessing a person's risk of self-harm or suicide and clear guidance for staff on what should be discussed, actioned and recorded;
- periodic training for mental health staff[41].

Furthermore, on 16 June 2011 the Parliament established the Joint Select Committee on Australia's Immigration Detention Network to conduct a comprehensive inquiry into Australia's Immigration Detention Network, including its management, resourcing, potential expansion, possible alternative solutions, the Government's detention values, and the effect of detention on clients. The Committee published its report in March 2012 identifying concerns surrounding the implementation of the PSP, particularly consistency between the Keep Safe policy and PSP, training in PSP and contract management[42].

Following feedback from various external agencies suggesting that the implementation of the program across detention facilities has been inconsistent, DeHAG recommended an independent evaluation of the implementation of the PSP.

Department of Immigration and Citizenship, covering the period 1 July 2010-9 June 2011. Available at: http://www.hreoc.gov.au/human_rights/. Accessed: 06/01/2012.

[40] Australian Human Rights Commission, *Australian Human Rights Commission Submission to the Joint Select Committee on Australia's Immigration Detention Network.* Available at: http://www.hreoc.gov.au/. Accessed: 06/01/2012.

[41] NSW State Coroner, 2011, *Findings in the inquests into the deaths of: Josefa Rauluni, Ahmed Obeid Al-Akabi, David Saunders at Villawood Detention Centre, New South Wales, in 2010*. Available at: http://www.coroners.lawlink.nsw.gov.au. Accessed 14/06/2012.

[42] Joint Select Committee on Australia's Immigration Detention Network, 2012, *Final Report.* p.xix. Available at: http://www.aph.gov.au/. Accessed: 15/06/2012. Australian Government, Canberra.

Evaluation objectives

The aim of this research was to evaluate the implementation of the PSP for the prevention of self-harm in IDFs, specifically:

- whether the PSP is sufficiently robust for the mental health challenges posed by immigration detention; and
- how well the PSP has been implemented.

The main focus of the evaluation was on the implementation of the program and the governance, structures and systems that support this implementation and ongoing management of the program.

3

In this section, details of the evaluation design

3. EVALUATION METHOD

The evaluation used a mixed method design to address the objectives. DIAC provided the evaluation team with a range of background documents and data as well as assisting the evaluation team to gain access to agreed IDFs to conduct site visits. DIAC also assisted the evaluation team through the review of evaluation tools including the evaluation plan, interview guides and online survey.

A summary of the method is provided in this section (Figure 1) followed by further discussion of each stage.

Figure 1: Evaluation map

Inception stage

Prior to commencing the evaluation, the Ipsos and Department teams meet several times to discuss the approach to the evaluation, content of the evaluation plan, materials and support available from DIAC, stakeholders to be consulted, IDFs to be visited and timing of deliverables. This initial information was used to develop the evaluation plan.

Review of documents and data

The program documents were reviewed to provide an understanding of the program theory and key design features. DIAC provided 81 documents for the evaluation. These included policy documents related to the PSP and health management in IDFs more generally, reports on self-harm in IDFs, PSP training materials and other background materials. These documents were largely used to provide descriptions of intended policy or procedures.

DIAC also provided a data file of reported incidents of self-harm across all IDFs from October 2009 to March 2012. The data was reviewed to identify any potential outcomes since the implementation of the PSP. The data included 3,831 reported incidents and included variables relevant to the incident, the environment and the individual. This data was used to examine the pattern of self-harm reported over the time period and factors associated with changes. This was a limited review conducted to inform judgments related to this evaluation rather than to inform broader questions about the nature of self-harm and its determinants in immigration detention. As this evaluation is at the system level, except where presented in the site visit case studies, data on self-harm was not examined at the individual IDF level.

Brief literature and model review

A review of literature was conducted to establish the need for the program, its policy connections and best practice principles in harm minimization in detention settings. The review sought to identify alternative processes and practices that may inform solutions to any gaps or barriers for the PSP identified by the evaluation.

This review briefly examined other models of reducing self-harm in custodial environments in Australia and overseas. The models selected for this review were: SASH Prevention (the fore runner to PSP) and the corrective services models used in New South Wales, Western Australia and the United Kingdom. The models review considered the program development, delivery methods, program content, training standards, assessment, outcome measurements, and impact on client outcomes, where evidence of these elements was available.

3.1.1 Stakeholder interviews

A total of 30 stakeholders from eight organisations were consulted as part of the evaluation. (A further 79 staff were interviewed as part of the site visits). Organisations consulted included both government and non-government stakeholders:

- Australian Human Rights Commission
- DeHAG
- DIAC, College of Immigration
- DIAC, Stakeholder and Health Strategy Section, Detention Health Services Branch
- IHMS
- Life Without Barriers
- Mental Health Sub Group of DeHAG
- Monash University
- Serco.

DIAC assisted by providing contact details for candidates. Candidates were then emailed a primary approach letter by Ipsos explaining the nature of the evaluation and asking for their participation in an interview lasting up to 1 hour. Ipsos consultants then contacted candidates by telephone to arrange an interview time. Consultations were conducted in April and May of 2012.

Consultations topics included:

- Governance and partnerships
- Implementation processes
- Training
- Communication processes
- Outcomes
- Overall views of the program.

In reporting qualitative feedback from stakeholders, comments or quotes have not been attributed to any organsiation. The opinions provided by stakeholders were personal opinions based on their professional expertise and experience.

3.1.2 Site visits and consultations with management, staff and clients (or their representatives)

Site visits were conducted to Sydney and the Northern Territory to the following IDFs:

- Villawood IDC
- Northern Immigration Detention Centre (NIDC)
- Darwin Airport Lodge (DAL) APOD (1, 2 and 3)
- Wickham Point IDC.

As part of the site visits, interviews and mini-group consultations were conducted with service providers (management and operational staff), DIAC (management and case managers) and other stakeholders in the detention network. A schedule of site visit consultations is provided in Appendix D.

Site visits explored awareness and understanding of the PSP, implementation of the program on site, training in the PSP, communication between agencies, and perceived outcomes of the program.

As with stakeholder consultations, in reporting qualitative feedback from IDF staff, comments or quotes were not attributes to any individual or organisation. The opinions provided by staff were personal opinions based on their experience.

3.1.3 Online survey of staff

A confidential online survey of staff experience with the PSP was conducted across six weeks in April and May, 2012. The online survey explored staff awareness, training, attitudes and confidence working with clients at risk of self-harm.

Participating agencies circulated an email invitation from Ipsos to their staff working in immigration detention. The email included an embedded link to an online survey hosted on Ipsos' secure servers. The online survey was voluntary and took around 10 minutes to complete.

A total of n=392 responses were received from the following agencies:

- DIAC staff: n=81

- Serco staff: n=212
- IHMS staff: n=89
- LWB staff: n=10

The questionnaire used for the online survey is provided in Appendix C. Of the 392 staff who responded to the online survey:

- 93% were aware of the PSP
- 89% worked at an IDF
- 86% worked with clients
- 82% worked with clients who were being supported through the PSP
- 35% had less than one year of experience in immigration detention

In the body of this report, where survey findings have been reported for the questions measured on a Likert scale (Excellent, Very Good, Good, Fair, Poor) only the top-two and bottom-two scores (and nets) have been reported (that is, good has not been reported). These scores provide the best discrimination of relative strength between variables and thus are better able to inform quality improvement decisions. These scores are also used for benchmarking, indicators and tracking as they are sensitive to changes in performance. Means on Likert scales have not been reported as the psychological distance between points on the scale is not known and the data has therefore been treated as ordinal.

3.2 Limitations of the evaluation

This evaluation was conducted on a small budget and over a short period of time. This limited the ability of the evaluators to conduct site visits to just two regions. The extent to which these setting provided the range of implementation issues experienced by the PSP is not known.

Participation levels in the online survey are not known because the invitation was distributed by third parties (employing agencies). While this ensured the confidentiality of staff contact details, it did provide challenges in gaining participation from some agencies and limited the ability of the evaluation team to monitor online survey completion rates.

3.3 Report structure

This report includes the following chapters:

Chapter 1: Executive Summary – provides an overview of the report

Chapter 2: Background – provides an introduction to the policy area supporting the PSP

Chapter 3: Evaluation method – provides an overview of the research design and methods

Chapter 4: PSP implementation and design – provides an evidence-informed review of the design and processes of the PSP, including program theory, staff training, preventions, privacy, access to after-hours assessment, and changes to the PSP since its implementation.

Chapter 5: Suitability of the PSP design – provides an evidence informed review of performance monitoring arrangements, self-harm (incident report) data and outcomes for staff.

4

This section provide a description of the PSP and its design features

4. PSP IMPLEMENTATION

This chapter provides an overview of the implementation of the PSP, including:

- PSP design
- PSP processes
- Prevention and engagement
- Privacy and confidentiality
- Access to after-hours mental health assessment
- Changes in implementation.

In 2008, DIAC commissioned Monash University to undertake an independent review of the existing approach to management of suicide and self-harm in the Suicide and Self-Harm (SASH) Protocol. SASH was primarily a reactive client management tool used to address security risks to ensure the orderly functioning of the detention environment[43].

In April 2009, in conjunction with the DeHAG and with reference to the Government's National Mental Health Policy, DIAC published three inter-linked mental health policies:

- Mental Health Screening
- Psychological Support Program

[43] Department of Immigration and Citizenship, 2011, *RFP For the provision of services to conduct an evaluation of the Psychological Support Program (PSP) implementation*. Australian Government, Canberra. Unpublished.

- Identification and Support of People in Immigration Detention who are Survivors of Torture and Trauma.

4.1 PSP design

A program logic model was developed to describe the basic structures and processes of the PSP (Figure 2). The primary inputs to the PSP are:

- The Detention Service Manual (Chapter 6: Psychological Support Program (PSP))
- The training program
- Data on the reported incidents of self-harm
- Existing service provider policies.

Of these inputs, the primary support is through the Detention Service Manual that sets out the policy underpinning PSP. The Detention Service Manual provides a definition of self-harm as "actions or threats of actions which, if carried out, may lead to self-injury or death." (p4)[44]

PSP as outlined in the Manual is to provide an integrated framework and set of principles to identify and support people who are at-risk of self-harm. The policy was developed with DeHAG to align with the Department of Health and Ageing's National Mental Health Policy and to reflect best practice in preventing self-harm.

The PSP 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.

The policy applies to all staff in immigration detention, with the policy being specifically tailored to immigration detention facilities.

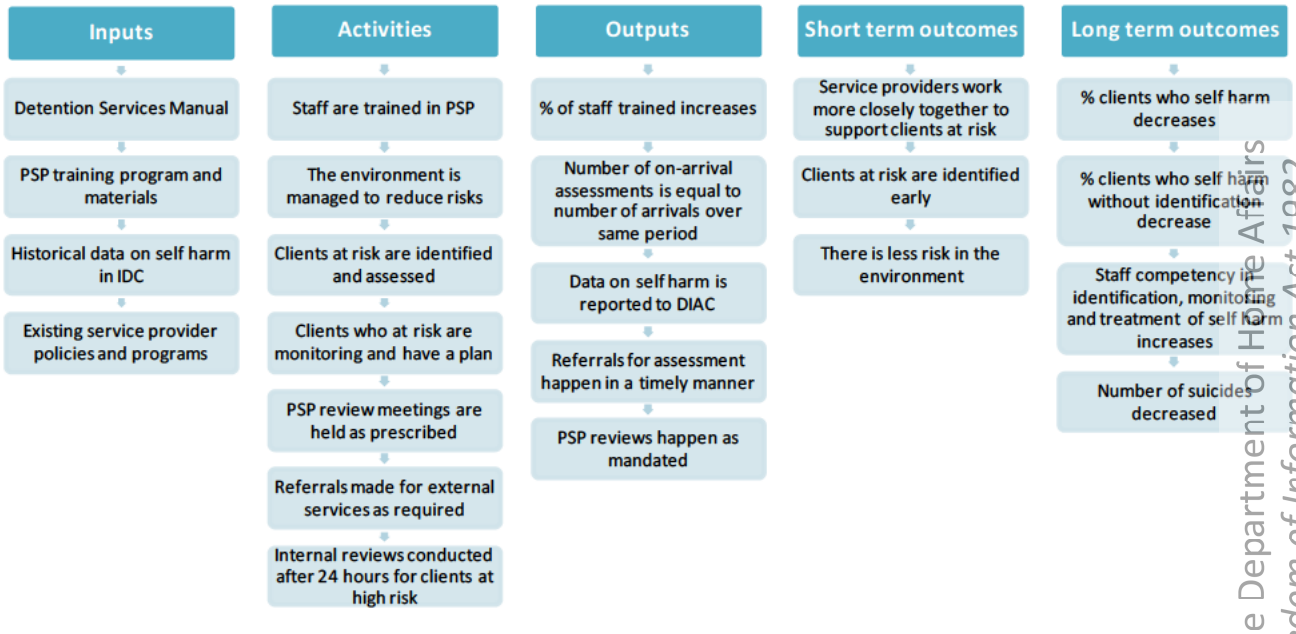
[44] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.

The intent of the policy is further set out in nine principles that underpin the prevention and management of self-harm for persons in immigration detention (p7):

- 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.

The policy includes information on definitions, risks, warning signs and protective factors in managing the self-harm.

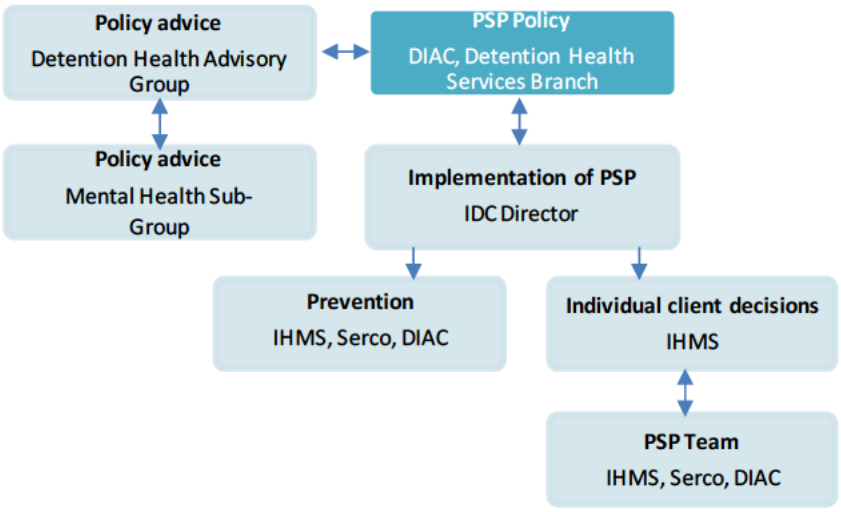
Figure 2: PSP program logic model



4.1.1 Program governance, roles and responsibilities

The PSP was developed by the former Detention Health Services Branch, Department of Immigration and Citizenship, with advice from DeHAG. Program implementation was overseen at each IDF by the DIAC site director, reflecting the site specific implementation plans developed following the introduction of the program in 2010. Oversight and ultimate responsibility for decisions relating to individual clients with regard to the program is the responsibility of IHMS, with input from Serco and DIAC staff and others through the PSP team (Figure 3).

Figure 3: Program governance structure



Roles and responsibilities in relation to PSP

The PSP policy requires that all parties in the immigration detention service involved in client support to (p 9)[45]:

- Work together to provide an environment that seeks to prevent self-harm by reducing risk factors and enhancing protective factors
- Participate in PSP team meetings and processes (including case review meetings and quality improvements)
- Keep complete and accurate records.

[45] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.

Specific roles are outlined in Box 1.

Box 1: Staff Roles

Department is responsible for:

- carriage of information relating to clients' visa pathway.
- collating incident reports relating to self-harm, and providing these as inputs to PSP quality improvement processes;
- working with the service providers to resolve issues that threaten the effectiveness of self-harm prevention arrangements; and
- conducting scheduled and triggered client placement assessments and detention review assessments.

Serco, acting as DSP, is responsible for:

- conducting initial self-harm risk assessment interviews (where appropriate) and referral of persons at-risk of self-harm to the IHMS;
- identifying to early warning signs and seek immediate advice from IHMS where risk of self-harm is suspected;
- following clinical advice from the IHMS;
- engaging with persons identified as at-risk of self-harm in a supportive way;
- recording meaningful observations of persons with supportive monitoring and engagement plans and ensure these are communicated to the PSP team;
- responding to any attempted or committed self-harm or suicide incidents and submitting incident reports to DIAC; and
- ensuring that responsibility for supporting persons at-risk of self-harm is transferred effectively at shift changeovers.

IHMS, acting as HSM, is responsible for:

- conducting initial and scheduled comprehensive mental health screening, as well as ad hoc

- assessments where an individual displays deterioration in their mental state or undergoes a significant change in their situation which may exacerbate distress (such as an adverse decision);
- developing and maintaining therapeutic relationships with persons in immigration detention provide advice to the Serco about levels of risk and strategies for engaging and supporting persons at-risk of self-harm;
- seeking out and using all collateral information when making assessments, providing care, and formulating advice regarding the management of persons at-risk of self-harm;
- referring persons for assessment by external health services where onsite support is unable to adequately cater for the mental health needs of person at-risk of self-harm; and
- providing a coordinated post-incident response in the event of a serious self-harm incident, including written reports to DIAC on any triggers or contributing factors identified through post-incident debriefing (with the PSP team).

PSP team arrangements

Staff from IHMS, Serco and DIAC consistently reported that PSP team meetings were held daily. The extent to which staff attending the meetings consulted with their internal colleagues about the client's recent behaviour or knew the client varied. DIAC case managers commented on a lack of information flowing from these meetings, including not being told their clients were on supportive monitoring and engagement plans.

The policy provides for a multidisciplinary PSP team to support the day-to-day management of cases involving risk of self-harm. The team is led by a senior clinician from IHMS and supported by representatives from Serco and DIAC.

While the PSP team aims for consensus, the senior clinician leading the team can make unilateral decisions on issues such as level of risk and response. Serco and DIAC must act on clinical advice or follow prescribed escalation procedures in the case of a disagreement.

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

- A senior clinician from the mental health team, who will act as the PSP team leader
- The Serco shift manager

- Departmental staff
- Other relevant people as invited by the PSP Team Leader[46].

Staff at site visits generally reported that daily team meetings were conducted, sometimes with place review meetings, and were an essential component of the program to be shared by all agencies. However the rigour with which PSP discussions occurred within these meetings varied from daily dedicated PSP meetings to a minute or two within a more general daily meeting. While daily meetings were routinely conducted and attended by senior members of all stakeholder agencies, the extent to which they consulted with operational staff before the meeting to gain up-to-date information on the client varied. DIAC case managers consistently reported having limited access to information about their clients who were actively on a supportive monitoring and engagement plan. Some case managers felt that they would work differently with clients if they knew they were on supportive monitoring and engagement plans (for example, speaking to client's IHMS contact before organising a meeting).

Staff reported a high degree of compliance with the documentation of monitoring activities and incident reports.

4.2 PSP processes

According to the policy, the PSP process "commences for all people in immigration detention at reception and continues while a person remains in immigration detention" (p 11)[47].

4.2.1 Assessment and referral processes

The PSP provides processes for assessment of self-harm risk on entry to immigration detention by Serco as DSP. This initial assessment includes a simple embedded decision tree to ensure that people with risk factors are referred to IHMS for comprehensive mental health screening and assessment at an early stage. When discussing the use of the initial screening questionnaire at site visits, staff generally found the assessment easy to use. Comprehensive screening and assessment is also triggered at critical points, such as adverse immigration decisions.

Where a client is referred to IHMS for a comprehensive assessment, whether through identification of need at reception, due to a trigger (such as adverse immigration decision) or other referral, site

[46] ibid
[47] ibid

staff general considered that clients were able to gain quick access to a mental health professional, during working hours.

"Wish I could get in to see a psychologist that quickly!"

4.2.2 Supportive monitoring and engagement

The PSP includes three self-harm risk levels that are determined by a member of the mental health team or other suitability qualified mental health professional as a result of a face to face assessment (Table 2). In summary, these levels are:

- High imminent risk - requiring 1:1 arms length monitoring, maintaining a line of sight of the client as all times.
- Moderate risk - requiring observation at intervals of 30 minutes.
- Ongoing risk – requiring some level of observation.

Table 2: PSP supportive monitoring and engagement levels

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 another mental health professional after 24 hours
Moderate	30 minute observations	A secure, safe but less restrictive environment	Every 24 hours
Ongoing	Ongoing – general nonintrusive	Normal accommodation	Every 7 days

Source: Department of Immigration and Citizenship, 2009, Detention Services Manual. Immigration National Office

Overall, feedback from stakeholders and staff during site visits was that the levels of supportive monitoring and engagement improved clients' safety. There were some issues noted that related to the operational implementation of the levels and flexibility to meet specific client's need:

- The need for a review every 12 hours for people on high imminent risk level is impractical where mental health clinicians are not available on site 24 hours a day and does not reflect the client lifestyle (eg, reviews can be triggered at the early hours of the morning when clients are asleep).

Recommendation 1: High imminent supportive monitoring engagement plans should be reviewed at least every 24 hours (more often where practical) rather than every 12 hours, to better reflect the operating environment and needs of clients (eg, a client assessed at 4pm currently requires reassessment by 4am).

- The 1:1 arms length monitoring for high imminent risk level can be too obtrusive for some clients and may contribute to their level of anxiety. While the policy does mention that "health professionals are trained in assessment of risk and must use clinical judgment in each situation." (p 15)[48] in a practical sense mental health clinicians did not feel they had the authority to alter the supportive monitoring and engagement arrangements associated with a risk level.

- The observations associated with both high imminent and moderate risk levels are difficult to implement when there are shared bedrooms. Particularly where a person already has disturbed sleeping patterns, the supportive monitoring and engagement arrangements can have a negative outcome for the client and their roommate/s.

Recommendation 2: The description of the three levels of supportive monitoring and engagement should be reviewed with clinicians to develop thresholds to delineating each level so that clinicians have more autonomy to tailor supportive monitoring and engagement plans to their client's needs. While this is the intent of the current PSP policy, the rigid description of each supportive monitoring and engagement level does not encourage adaptation to clients' individual needs.

- Staff conducting monitoring are not trained in supportive engagement. As a result, supportive engagement is not an aspect of monitoring (for high imminent or moderate PSP levels). Supportive monitoring and engagement was not seen as a higher skill but as a simple audit process.

Recommendation 3: The supportive monitoring and engagement plan should be separated into two components (monitoring and engagement) and clearly specific how Serco staff are to engage with the clients, beyond monitoring alone. The current approach encourages observation rather than engagement by Serco staff. This model would also encourage improved communication between IHMS and Serco operational staff in developing and implementing engagement plans.

- In addition, as mental health clinicians cannot access the detention environment without a Serco staff member (and often require an interpreter as well), some clinicians felt that the lack of clinical observations impacted on their ability to provide high quality care to people with a mental health condition. In addition, the separation of the mental health team from the main

[48] ibid

environment of the detention facility was seen by some clinicians as limiting opportunities for the mental health team to build rapport with clients and reduce stereotypes relating to mental health. There were seen to be some environments, where the security risk was low, where IHMS staff could be allowed to access the centre in pairs with electronic communication with the security staff to provide outreach support to clients.

4.3 Staff training

About half of the staff who completed the online survey (and had client contact) had not received any formal PSP training. Even among those staff who had accessed the training, the availability of training was still not highly regarded. Given that many staff in IDFs are on short-term employment contracts, and move between IDFs, the importance of access to nationally consistent, ongoing training was emphasised by staff at site visits. There was also a strong sentiment that the focus of the training was too much on policy understanding and mental health awareness, rather than practical skills to recognise and support clients at-risk of self-harm. The perceived lack of access to staff training was compounded by the lack of user-friendly implementation guides, process charts and other materials to reinforce the PSP procedures.

Training courses in mental health policy and awareness were delivered across the immigration detention network from mid-2010 to support the implementation of the PSP policy. This training was developed and delivered by members of the DeHAG and approximately 1,200 staff (from DIAC, Serco and IHMS) were trained in the initial rollout. The format of this training aimed to accommodate the needs of staff with different levels of access to clients by offering three day, two day and three hour programs.

Since that time, Serco, IHMS and DIAC all include mental health awareness in their pre-deployment training programs, although there are significant differences in the content and time allocated to this training. For example, DIAC case managers received approximately 2 ½ days of mental health specific course content, whereas Serco officers receive about three hours. A more general one day refresher course focusing on mental health policy awareness, aimed at all staff working within the detention environment, was piloted from mid-2011 and has been delivered across immigration detention network since then. Some 1,374 staff have received this training. The online survey results on PSP training may reflect feedback from any of these training programs[49].

Less than half of the staff responding to the online survey reported that they had attended formal training that included the PSP (47%) while nearly two-thirds of staff had completed some form of general training in mental health (64%). This is consistent with the staff interviews conducted

[49] Department of Immigration and Citizenship, personal correspondence, June 2012.

during site visits where training on the PSP was often reported to be a small part of a larger mental health awareness training program and described as being 'easy to overlook'.

"I think there was training on PSP. They might have just said read the Manual. I'm not sure."

Online survey respondents who had undertaken PSP training reported low levels of overall satisfaction with the training (25% excellent/very good) and low satisfaction with the availability of PSP training (17% excellent/very good).

Most staff interviewed at site visits who had done PSP training generally reported either having completed policy training when the PSP was first introduced or a few hours training on the PSP as part of a broader induction training program. Staff generally raised concerns that the training was more focused on policy and mental health awareness than providing practical skills for working with clients who were at-risk of self-harm. Some staff also commented on the needs for a regular program of training given the short-term nature of many employment contracts in immigration detention[50].

"I've never done it [training]. *I've read the booklet on PSP training."*

"I've done general mental health training. There should be PSP training, but I don't think I've done it."

The duration of the PSP courses was also not highly regarded by staff who had received training (19% excellent/very good). PSP was generally seen as 'too brief' in induction training, while longer courses on site were not seen as practical to manage.

"The idea of delivering training on-site is a good idea but is not well designed and structured...three days is a long time. I only attended one day because I found it hard to be away from my job for longer."

The level of satisfaction with training materials and level of PSP training were also quite low (25% excellent/very good each). Through interviews at site visits, staff raised concerns regarding how well the training prepared staff for working with clients. Several staff commented that the information was interesting but not necessarily relevant to their job. For example, DIAC and Serco staff commented on receiving training on mental health diagnosis when they are not permitted to know the mental health diagnosis of their clients.

"The training lacked a bit of practical knowledge".

"We talked about the PSP [in the training] *but not how it actually works at the centre."*

[50] 35% of staff responding to the online survey had worked in the current role for less than 1 year. Many staff interviewed at site visits were on contracts of six months duration or less.

Satisfaction with the knowledge of the presenter was the highest rated aspects of PSP training although the overall level of satisfaction was still moderate (36% excellent/very good). Staff commented during interviews at site visits that it was important to have the training delivered by a presenter who could answer questions about practical implementation in a detention environment and mental health. The importance of case studies and practical examples to contextualise information was seen as very important.

"It was very frustrating. I was asking questions that were relevant to the management of my clients' and the presenter just kept saying she wasn't qualified to give an answer. One of us shouldn't have been there."

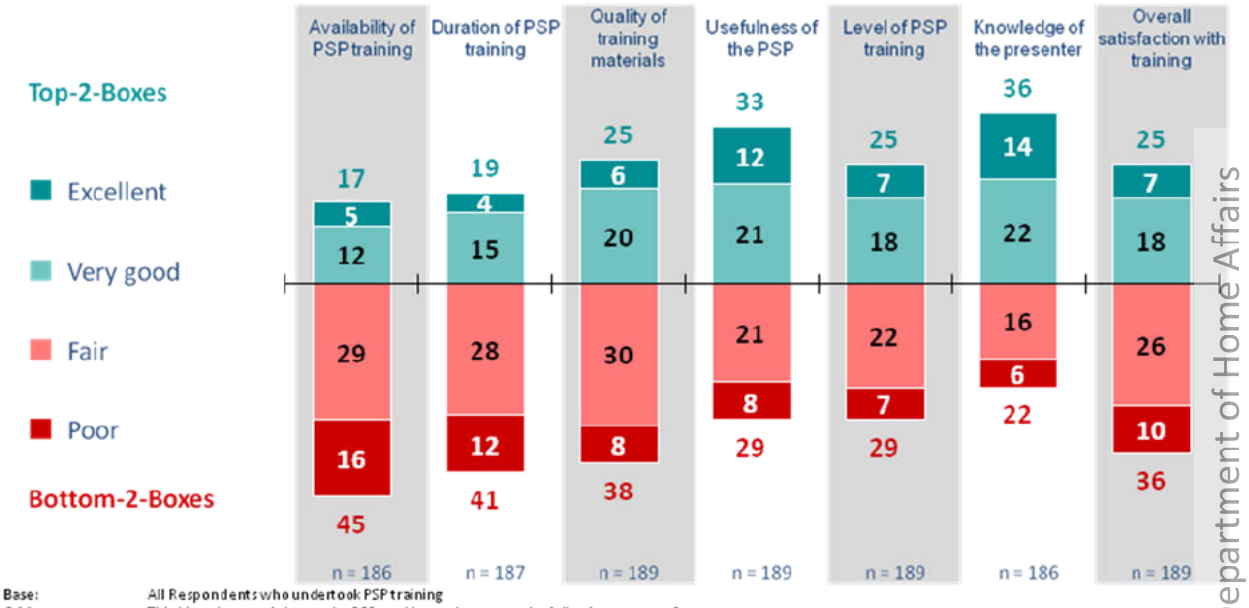
"It was great being there with IHMS. They added a lot of really practical examples."

The degree to which staff reported the PSP training was useful for their day to day job was moderate (33% excellent/very good). At site visits, a number of staff commented they had not had the opportunity to implement the training as they did not have a significant amount of client contact and/or that the training was not necessarily designed to equip them in implementing the policy, rather this was something they learnt on the job.

"It's very theoretical training and I've not had the opportunity to implement it."

"I've learnt about it [the PSP] *on the job."*

Figure 4: Quality of PSP training



Base: All Respondents who undertook PSP training
Q11: Thinking about training on the PSP could you please rate the following aspects...?

Recommendation 4: IDF staff should have access to nationally consistent initial and ongoing competency-based training on the PSP that is relevant to their engagement with clients. Such training should include clear learning objectives and evaluate training outcomes.

4.3.1 Staff resources and support material

Chapter 6 of the Detention Service Manual is not easy for staff to engage with as an operational guide. Summarising the PSP procedures for staff through checklists and flow charts, in the policy manual as well as through other materials (such as posters) would help reinforce key messages.

Over half of the staff who responded to the online survey learned about the PSP by reading the policy manual (53%). In the site visits, staff described the sections of the Detention Services Manual that related to the PSP as 'dense', 'overly long', and 'not really providing practical direction'. The Manual does not include any procedural diagrams or decision charts that would provide an overview of the procedures. There were no apparent posters or visual reminders about the PSP evident in offices, meeting rooms, lunchrooms or elsewhere during site visits.

In addition, the Manual's lack of user-friendliness was demonstrated by the many misbeliefs held about the PSP that were clearly contradicted by the Manual. For example, that PSP does not have a mechanism for clients at-risk to be monitored in the absence of a mental health assessment, that a mental health professional cannot alter the way each level of supportive monitoring and engagement is implemented, that PSP is only about monitoring (so people come on and off PSP), etc.

The Manual also does not provide tools or materials to help implement the PSP. Alternatively, KeepSafe was suggested as providing a very-user friendly design, supported by clear checklists, decision trees, templates and other materials to assist implementation.

4.4 Prevention and active engagement

In consulting with staff at site visits, there was a strong view that the PSP was an observational-based risk management program which included a referral pathway to mental health assessment and treatment. The two steams were seen as disconnected, with monitoring managed by Serco and assessment and treatment managed by IHMS. Serco staff were not seen as trained to offer 'meaningful engagement' to clients who were at-risk.

IDF staff did not see the PSP as involving prevention at a centre or system level. They often saw themselves as helpless to prevent self-harm. The exception to this was the introduction of supportive monitoring and engagement automatically around adverse immigration decisions.

PSP was strongly associated with monitoring – for staff interviewed at IDFs, the PSP was synonymous with being 'on' or 'off' monitoring. Supportive monitoring and engagement plans were seen as an observational framework with 'engagement' aspects rarely in evidence for people with high imminent or moderate risk assessment levels (outside of the role of IHMS). There was general agreement that Serco staff were not trained to do active engagement with clients who were at-risk. In one example the evaluators observed, a Serco staff person on his first day of work in an IDF was undertaking 30 minute observations for a client who had been assessed as at moderate risk. The staff person had not completed any training in PSP, did not know the client or the IDF environment. This assignment demonstrates that PSP supportive monitoring and engagement is not seen as an advanced skill. It is not seen as part of a client's care and treatment but a risk management tool.

Many staff commented that the PSP was too late in the development of self-harming behaviour and that a greater emphasis was needed on meaningful activities to build self-esteem and other protective factors for clients. National stakeholders and IDF mental health staff commented on the need for stronger partnerships between the community and IDFs, programs to develop clients' employment and self-help skills, volunteer programs to build protective factors such as personal resilience and social relationships. Some IDFs were identified as having best practice models for community engagement. These models generally involved activities such as: engaging community volunteers to teach clients employable skills (such as trade skills), self-sustainability skills (such as kitchen garden skills, banking, English language skills, etc), relaxation skills (including musical instruments, yoga, etc). These examples were seen as developing resilience of individuals and preventing self-harm through meaningful engagement. However, these activities were not seen as being related to PSP by the informants (staff working at IDFs) but part of a general best practice model of detainment.

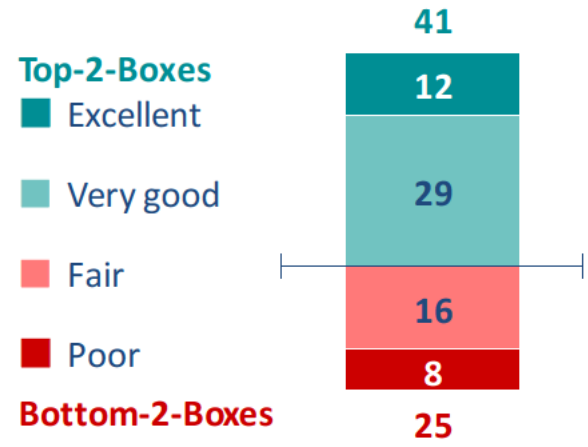
During site visits, Serco staff aware of the PSP policy commented that many of the examples provided in the Detention Services Manual relating to the management of environmental risk for people on a PSP monitoring and engagement plan, were not practical to implement in a shared living environment (eg, removing clothing, shoelaces, etc). IHMS staff provided some examples where clients at high imminent risk level were temporarily re-accommodated to 'safe' environments such as a high dependency room. These environments often had dual purposes to manage clients who had conduct or disciple behaviours. This was not seen as an appropriate placement for clients who were already vulnerable.

"The high dependency room is in an area of high activity. It's not conducive to supporting people [at risk of self-harm]. Everyone can see the client."

While some staff felt skilled to management the environment to limit self-harm (Figure 5), mental health staff were particularly likely at site visits to report that there was little they could do to prevent self-harm.

"The only way to stop self-harm is to give them their visas quicker and I can't do that."

Figure 5: Managing the environment to limit opportunities for self-harm



Base: All Respondents (n = 365)
Q13: Thinking about the prevention of self-harm, please rate how competent you feel in the following areas...?

Recommendation 5: The preventative focus of the PSP needs to be strengthened. This may include a range of activities such as improved cultural awareness, showcasing best practices in prevention from each IDF, improving the integration of IHMS mental health teams into the IDF environment (which may include mental health outreach service models) or increased engagement of clients in meaningful activity

4.5 Communication

The successful implementation of the PSP requires good communication and planning between DIAC and service providers. From the site visits and stakeholder consultations, it was apparent that there was considerable goodwill between organisations and evidence of close working relationships. In talking about the PSP, without exception staff focused on the levels of monitoring and related communication and planning processes. Generally, communication and planning around PSP client risk level was not well regarded by staff:

- Most Serco staff felt that their clients at-risk would be better supported if the Serco team had better access to information about behaviour and treatment from IHMS.
- DIAC case managers reported usually finding out their clients were on supportive monitoring and engagement plans through observation or reading daily incident reports.

- Some IHMS felt that they could be better informed about their client's behaviour if they were able to access the IDF without a Serco staff member with them. Relying on the notes of an untrained observer was not seen as an ideal arrangement.

From the online survey it is apparent that all areas of communication measured that related to clients at-risk of self-harm or being actively monitored through the PSP were well below an acceptable level (Figure 6).

Communication 'within your own organisation' about clients in relation to PSP was rated as excellent/ very good by just 30% of respondents. IHMS were generally slightly more positive about their internal communication systems than were other agencies (48% excellent/ very good compared to 23% for Serco and 22% for DIAC). At site visits both Serco and IHMS staff mentioned the use of case management arrangements for clients identified as at-risk to improve support to the client and communication within the organisation. Some DIAC case managers at site visits reported that they were generally only aware that a client had been assess as at risk if they read the daily incident report updates which relate to high imminent risk.

"Sometimes the first thing you know about a client being on PSP is that you find a Serco staff member trailing them around when you go to visit them."

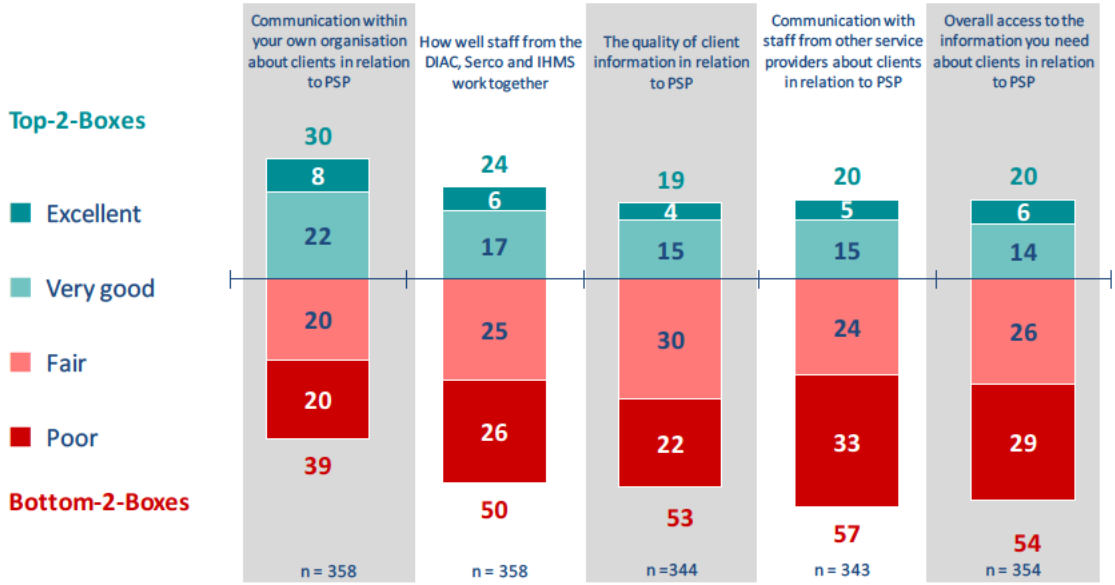
The ability of DIAC, Serco and IHMS to work together was also not highly regarded by the staff who responded to the online survey (24% excellent/very good). Staff from Serco were nearly twice as likely to rate this area as fair/poor (64%) than were staff from IHMS (34%) or DIAC (36%). Similarly, communication with staff from other service providers about clients in relation to the PSP was rated as excellent/very good by one fifth of staff (20%) responding to the online survey. This was a particular concern for respondents employed by Serco with nearly three-quarters (72%) offering a rating of fair/poor.

The quality of client information in relation to PSP was quite low (19% excellent/very good). Again, staff from Serco rated the quality of client information in relation to PSP particularly low (65% fair/poor compared to 30% from IHMS and 49% from DIAC).

In stakeholder interviews and site visits concern was also raised about quality of information shared between providers. This particularly related to access to information that may affect a client's risk or relate to a change in their behaviour.

"A client might start walking around humbling to themselves. I could think they are praying because no one told us [Serco] that...they have a mental health problem...and they are actually hearing voices or hallucinating."

Figure 6: Communication about the PSP



Base: All Respondents
Q12: Thinking about how you see the PSP being implemented in your current workplace overall, please rate the following aspects...

Recommendation 6: IHMS, Serco and DIAC should develop a joint communication strategy for sharing information about clients at-risk of self-harm. This strategy should also document internal agency communication strategies. All staff working with a client assessed as at-risk should have access to a common agreed level of information about the client to manage that risk.

The PSP model encourages an episodic management approach to at-risk behaviour. DIAC, IHMS and Serco each have their own internal case management systems. There are no formal structures for co-ordinating these different case management systems outside of the PSP team meetings. For clients with a high ongoing risk of self-harm, this potentially means that their care is not coordinated until it has reached a critical level. Given the cultural issues that exist between Serco and IHMS, DIAC or Serco welfare workers may be the best to manage an extended case management model.

Recommendation 7: Where a client is identified as at ongoing risk of self-harm, through an underlying aetiology or history of behaviour, an extended case management procedure should be available to coordinate their ongoing support across agencies to reduce their future risk.

4.6 Privacy and confidentiality

At present, the PSP policy does not provide an avenue for IHMS to share health information with other agencies involved in the client's support. At the simplest level, providing an avenue for IHMS to ask a client's permission to share relevant health information with other agencies could help improve information sharing. There are also deeper cultural issues that affect Serco and IHMS that has lead to distrust between some staff.

While there was generally agreement that information sharing between agencies had improved with the implementation of PSP, there was still seen to be room for further improvement. Privacy of health records was raised during site visits as limiting the ability to share information. Some mental health staff felt that sharing information with either DIAC or Serco would limit the extent to which the health team was trusted by clients. A minority of staff commented that health information could be used to stereotype clients.

While privacy was raised as a reason for not sharing information during site visits, staff also commonly mentioned that clients were not asked their permission to share information. Some stakeholders mentioned that clients are required to provide consent for sharing information when they first enter immigration detention. However, this could not be considered to constitute informed consent relating to the release of specific information for conditions that may not have been present at the time of consenting.

"If Serco want to know about someone's mental health information then it has to be formally requested in writing".

The approach described during site visits is consistent with the PSP (p10)[51] which describes the information that IHMS (as the HSM) may provide through PSP meetings and provides for an escalation process beyond that limited provision. The PSP does not have a pathway that allows clients to provide informed consent for the release of additional information. In addition, the policy does not recognise that Serco (as DSP) in part works in a caring role (providing accommodation, meals, and informal emotion support) and may require access to health information to execute that role. In executing this role, it is likely that on occasion the quality of the care provided would be increased with additional access to information, with the client's consent. Asking the client's permission before sharing health information potentially reinforces the confidentiality with which this information is treated and should further build trust.

[51] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.

Recommendation 8: The PSP procedures should be amended to allow IHMS staff the option of consenting clients to share mental health information with other agencies involved in their care, for the purpose of better management of their risk of self-harm and preventative engagement.

4.7 Access to afterhours mental health assessment

Access to the mental health assessment after-hours was raised, particularly for the centres in the Northern Territory. When a client is referred for mental health assessment after-hours, the mental health team response promptly on their return to work the next day. Where there is immediate concern about a client's health, staff have access to a triage line managed by IHMS. Staff who had accessed this line raised concerns about the usefulness of using this line for mental health concerns as the line was not manned specifically by mental health professionals. As a result, advice received through the triage line was described as 'risk adverse' and likely to refer the caller to community health and emergency services. There were also reports of staff waiting over an hour for advice through the triage line. Some staff also reported that the triage line could not make an interim assessment for PSP supportive monitoring and engagement. At Wickham Point IDC there was a pilot using IHMS mental health staff to support a mental health triage line. This provided a pathway for IHMS mental health staff to attend the IDC after-hours. It was reported during site visits that this arrangement was being trialed due to the remoteness of site and difficulties in accessing after-hours mental health services.

From site visits, there was general agreement among staff that PSP does not have a procedure for supportive monitoring and engagement where a client is referred for mental health assessment after-hours. This is not the case. PSP has the following arrangements in place for when staff become aware of a self-harm or suicide risk when mental health clinicians are not available to make an assessment[52]:

- That Serco commences supportive monitoring and engagement immediately and maintains such monitoring until a mental health clinician has made an assessment of the person's level of risk.
- Where the person has self-harmed an assessment for physical treatment should be referred to a clinician (emergency services, triage line, etc).
- That the Serco and DIAC's shift managers or duty workers are contacted as soon as possible via the duty phone in line with local PSP and Incident Reporting procedures.

The PSP policy documents make no reference to 'after-hours' procedures. While these procedures are included in 'Supportive monitoring and engagement in the absence of a mental health clinician

[52] ibid

(p 21)[53]' this difference in terminology may have contributed to a lack of awareness in the PSP procedures for managing clients at-risk of self-harm while waiting for assessment by a mental health clinician.

In the absence of awareness of the PSP procedures, Serco staff use their KeepSafe policy to provide an observational framework to manage the self-harm risk after-hours. The use of this internal policy caused some points of confusion:

- IHMS mental health staff were unclear how KeepSafe was reviewed once a mental health clinician had conducted a risk assessment. There were numerous examples given where a client was seen as being actively monitored through both PSP and KeepSafe.
- There was confusion from some IHMS mental health staff about the use of KeepSafe for reasons other than mental health concerns (i.e. other risk) as the application of KeepSafe was bound to perceived gaps in PSP procedures after-hours.
- There was a tendency for mental health staff to consider that KeepSafe was used when the judgment of the mental health clinician was not supported by Serco staff.

The PSP needs to provide a framework for managing self-harm risks irrespective of the time of the day that they occur or the availability of a mental health clinician. The use of KeepSafe for managing client's at-risk of self-harm after-hours demonstrates that the awareness of provision of after-hours care is inadequate.

Recommendation 9: The after-hour's arrangements in the PSP policy documents should be clarified so that the policy communicates more clearly the 24-hour referral, assessment and protective care pathways for clients identified as at-risk when a clinician is not available.

4.8 Changes to the program design since implementation

Since its implementation, there has been one major change to the design of the program. Initially, clients assessed as high imminent risk were required to be assessed by an external mental health professional after 24 hours. The need for an external review was changed to allow for review from another member of the mental health team. This change was made in recognition that in some locations it was difficult to access an external mental health professional within the prescribed time.

[53] ibid

5

This section provide a detailed review of the suitability of the design of the PSP

5. SUITABILITY OF PSP DESIGN

This chapter of the evaluation will address the suitability of the PSP to meet the needs of clients and staff within the demands of the immigration centre environment. This will include discussion of:

- Performance monitoring
- Self-harm data
- Outcomes for staff

5.1 Performance monitoring

The PSP does not have any performance targets to monitor its implementation or measure success. While there is post incident evaluation, where is occurs it happens at the local level and will not necessarily inform system improvements.

The Detention Service Manual provides very limited information on performance monitoring, quality improvement or evaluation of the PSP. The focus of review in the Manual is on post incident evaluation to improve self-harm prevention, identification and response arrangements[54]. While this is an important process to undertake, it is a reactive measure that does not provide an appropriate level of oversight of the performance of the policy at a system level. It was also reported that this does not occur consistently and that there are no structures in place for cross-agency review.

The PSP lacks a formal evaluation framework and performance targets. There appears to be no evaluation of training or workplace assessment of competency post training. While there is data

[54] ibid

available on self-harm in immigration detention centres, the data is not used as part of a performance management framework for monitoring the program.

Developing targets or indicators of performance against which to measure PSP is difficult and likely to involve multiple measures with varying degrees of causal relationship with the PSP. A brief discussion of possible indicators is presented in Table 3. Without targets in place, there is no standard against which to monitor the implementation of the PSP.

Table 3: Issues in setting performance targets or indicators for the PSP

Possible indicators	Discussion
Number of people who are reported to self-harm	Measures of an absolute number are subject to changes in the population. A rate or ratio of self-harm within the population avoids this to some extent. A limitation of this approach is that the relationship between the population and self-harm is exponential so self-harm 'rate' is not a constant proportion of the population but a variable rate that may be reflective of other factors, such as overcrowding and length of stay. Similarly, some groups of the population are more at-risk of self-harm than others (eg, men have a higher risk than women, young men have a higher risk than older men, etc). The proportion of the population at risk will vary over time. To be reliable, the targets should focus on the risk level of difference sub-populations. As the incidence of reported self-harm (whether presented as an absolution number or proportion – fixed or variable) is measured rather than actual incidents, the measure has elements of subjectivity (particularly around the application of definitions by different observers). This process may be supported by the use of indicators that monitor severe self-harm or suicide as these cases will be less subjective in nature (say than threatened self-harm) and more likely to involve multiple agencies reducing integrity issues and improving reliability in reporting.
Actual number of people who have self-harmed resulting in medical treatment	Another possible measure of self-harm is around the access to medical treatment. For example, need to be seen by medical staff, Emergency Department presentations, hospital admissions, length of admission, etc. The issues discussed earlier relating to rates and identifying the population of interest also apply. Indicators of this nature provide a level of severity of self-harm and include an element of independence obtained

	through a medical review. However, there is a perverse indicator for non-referral making compliance and integrity issues important to incorporate when using this type of indicator.
Number of staff who are trained in the policy	A simple output measure is the number of staff who have been trained in the PSP. Given the extensive use of short-term contracts in IDFs, again this information will be more meaningful as a proportion than an absolute number. This measure does not consider the outcome of training on its own.
Number of staff who have independently been assessed as competent in implementing the policy	To measure the outcome of training, a measure the competency of staff post-training needs to be considered. Measures to achieve this include pre and post training inventories of skills, knowledge and/or attitudes; self-reflective post training surveys; and workplace assessments. These measures have different resourcing implications. There measurement may be applied to the population of trainees or measured through a sampling approach.
Staff time off work as a result of incidents (eg, post traumatic stress disorder)	Other measures relate to staff. For example, staff access to mental health services post self-harm events, staff time off work as a result of an incident, etc. These measures address the suitability of workplace practices to support staff working with clients who self-harm. They also provide a proxy for severity of self-harm to some extent.

Recommendation 10: A nationally consistent strategy needs to be developed to guide the implementation and monitoring of the PSP. This national strategy should include clear targets to measure the performance of the PSP. These targets should be incorporated into contract management systems.

5.2 Self-harm data

In summary

There is evidence that reported incidents of self-harm increased after the introduction of PSP. This may in part reflect increased awareness and reporting of self-harm generated by the introduction of the PSP. This is a positive outcome for clients as identification will lead to a mental health review.

Population size and time in detention were found to have an exponential relationship with self-harm. While the time in detention has decreased over recent months (largely due to the number of Bridging Visas granted) the population size has not decreased due to the increase of IMAs over this same period.

There was no indication that PSP had reduced the incidences of self-harm, though it is possible that without PSP there would have been a greater increase in self-harm as a result of increases in population and time in detention.

There were serious integrity issues raised about the validity and reliability of reported self-harm data by stakeholders, given the lack of agreement of variable definition and subjective nature of referral for assessment.

Incarceration is a known risk for suicide. People in any form of custody have a suicide rate of up to three times higher than the general population[55]. A study of deaths in Australian prisons conducted in 2000 found that self-inflicted injuries[56] accounted for 41% of all custodial deaths in that year (36 of 88 deaths in that year, making it the most common manner of death); hanging was the leading cause of death (49% of all prison deaths)[57]. In 2008 self-inflicted deaths were at their lowest in Australian prisons since 1980 with ten recorded cases of hanging deaths[58]. The average rate of non-fatal self-inflicted injury was more than twice that of the general community[59]

[55] Mindframe media, 2012, *Further Facts/Statistics,* Available at: http://www.mindframe-media.info/site/index.cfm?display=84351. Accessed: 17/05/2012.
[56] Self-inflicted injury is 'any action which is potentially suicidal or self-destructive regardless of whether or not it is believed to be a genuine attempt at suicide. Threats not accompanied by actions are not included'.
[57] Collins, L., and Mouzos, J. 2001, *No. 217 Australian Deaths in Custody and Custody-related Police Operations, 2000*. Available at: http://www.aic.gov.au/ . Accessed: 17/05/2012. Australian Institute of Criminology, Canberra.
[58] Lyneham M. et. al., 2008, *Deaths in custody in Australia: National Deaths in Custody Program 2008.* Available at: http://www.aic.gov.au/. Accessed: 14/05/2012. Australian Institute of Criminology, Canberra.
[59] Biles D. and Mc Donald D, 1992, *Deaths in custody Australia, 1980*-1989. p.418. Available at: www.aic.gov.au. Accessed: 14/05/2012. Australian Institute of Criminology, Canberra.

and the Royal Commission into Aboriginal Deaths in Custody found sixteen times as many incidents of self-harm as completed suicides in custody over a six month period[60].

The literature reports that there is limited data on the incidence of self-harm in immigration detention due to issues in collection, management and reporting of health data sets[61]. Specific problems include a lack of agreed definitions for self-harm and attribution of motivation in definitions.[62] DIAC is currently undertaking work to develop an improved incident reporting framework.[63]

Self-harm data in immigration detention centres since the implementation of PSP

DIAC provided data on the reported incidence of self-harm in IDFs from October 2009 to March 2012. This information included descriptive variables such as personal and environmental characteristics. In discussions with personnel engaged in the reporting and analysis of data, it was acknowledged that there was considerable differences between IDFs on what incidents are reported and how they are categorised. There was no commonly agreed definition of self-harm or levels of severity. There was no testing on the inter-rater reliability of completing incident forms. It was generally agreed by staff reporting and managing self-harm data that the reported incidents would be an under-representation of the actual incidents, particularly in relation to threatened self-harm which may been seen as a conduct issue or political statement, rather than the result of a psychological or psychiatric motivation, and incorrectly not recorded. It is important to note that the analysis of data in this section was conducted for the purpose of identifying potential outcomes for clients as a result of the implementation of PSP. Analysis was not undertaken to identify the causes of self-harm.

The data provided by DIAC related to 3,841 cases, including actual self-harm (1,274 cases, 33%), threatened self-harm (2,362 cases, 61%) and serious attempted self-harm (205 cases, 5%). The mean number of days in detention was 313 and vast majority of clients were males (96%) aged under 35 years (82%). Self-harm commonly occurred in following a negative assessment (52%), though the time lag is not known.

Data analysis

Analysis of the incidents of reported rates of actual and attempted self-harm over time showed an increase in incidents after the implementation of PSP, peaking in late 2011 though still remaining high in March 2012 (Figure 7). This may reflect an increased importance placed on reporting of

[60] Schrader, T., 2005, *Submission to the Senate Select Committee on Mental Health*, p.3. Available at: http://www.aph.gov.au. Accessed: 17/05/2012.
[61] Casey, D., 2011, *Review of the detention health framework – A policy framework for health care of people in immigration detention*. Unpublished.
[62] Prof. Newman, L., 2011, cited in *Detainee self-harm 'worse than figures reveal'* ABC News (29/07/2011). Available at: http://www.abc.net.au/. Accessed 18/05/2012.
[63] Department of Immigration and Citizenship, 2011, *Key issues summary on incident and health reporting.* Unpublished.

self-harm as a result of training and implementation of reporting mechanisms associated with the PSP. This is supported by the disproportionate increase in the reports of threatened self-harm (which is a more subjective rating than actual self-harm).

This observed increase in incidents of attempted and actual self-harm coincides with an increase in the population of IDFs (Figure 8). Comparing the patterns of incidents of self-harm and population size suggests that population increase has an effect on actual and attempted self-harm with a lead time of about three to four months.

Figure 7: Tends in the incidents of self-harm in IDF (2009-2012)

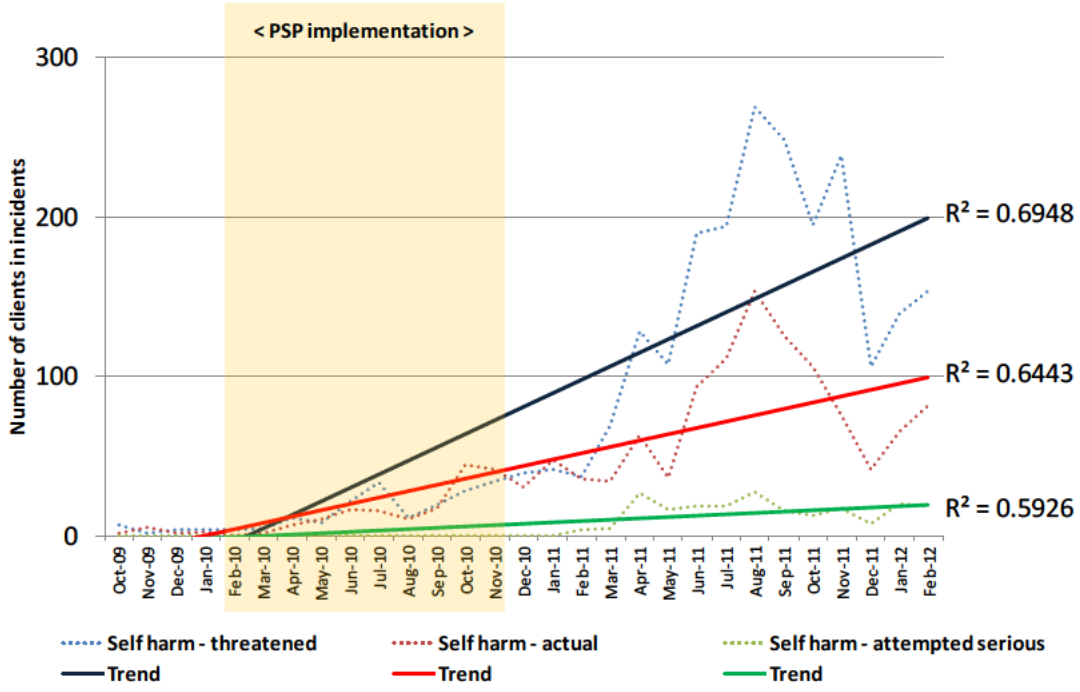
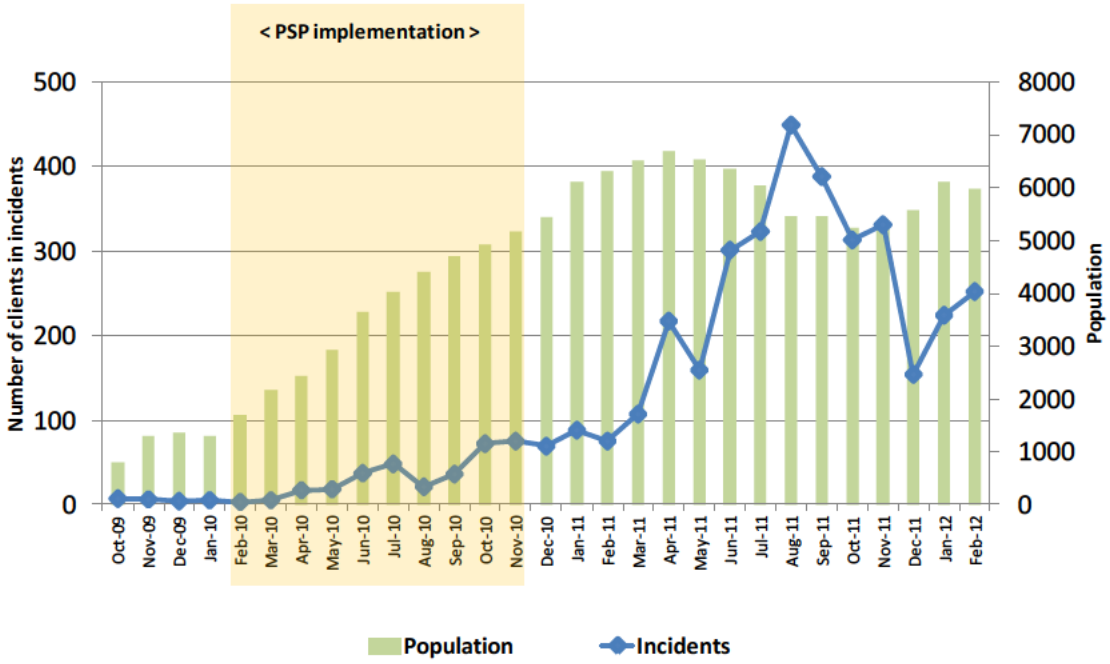
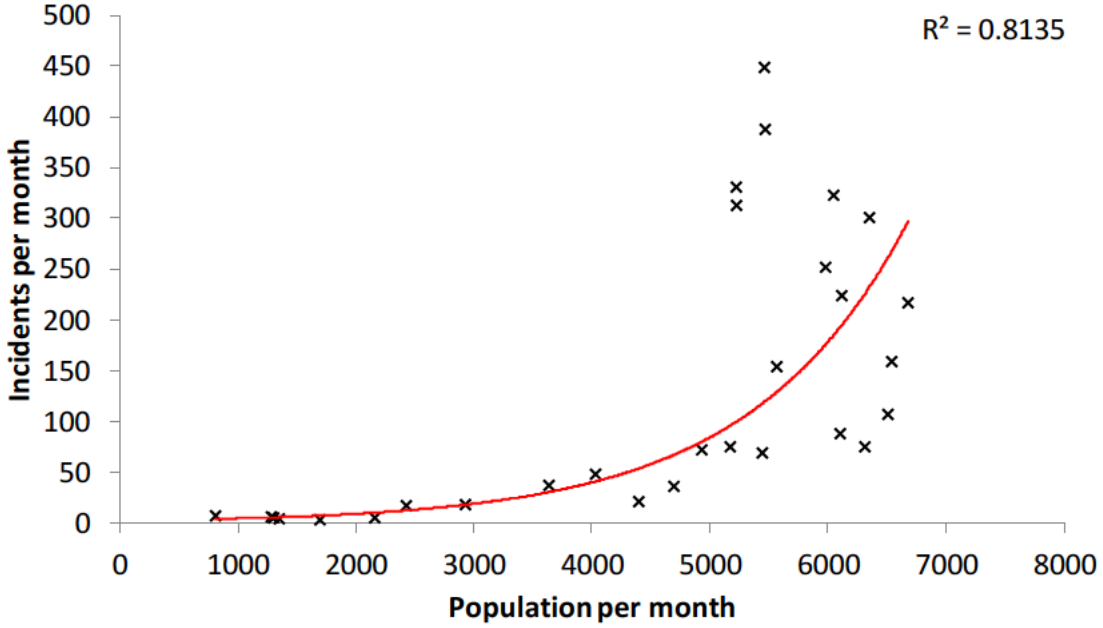


Figure 8: Tends in the incidents of self-harm in IDF (2009-2012)



Further analysis revealed an exponential relationship between reported incidents of self-harm and population in IDFs (Figure 9).

Figure 9: Relationship reported incidents of self-harm and IDF population



The analysis also reveals a relationship between incidents of self-harm and the length of time in immigration detention. It would also be expected that length of time in immigration detention increases as a result of population increases, due to extra demand on resources to process and review client applications. Comparison of self-harm to average time in detention by month does show a similar trend but not as marked as observed with population (Figure 10). As with population size, there was found to be an exponential relationship between length of time in immigration detention and reported self-harm (Figure 11).

In relation to when self-harm occurs during a client's detention, while the pattern of self-harm does demonstrate some relationship with length of time in detention, incidents are spread across the time spectrum (Figure 12).

Figure 10: Reported incidents of self-harm and average time in detention by month

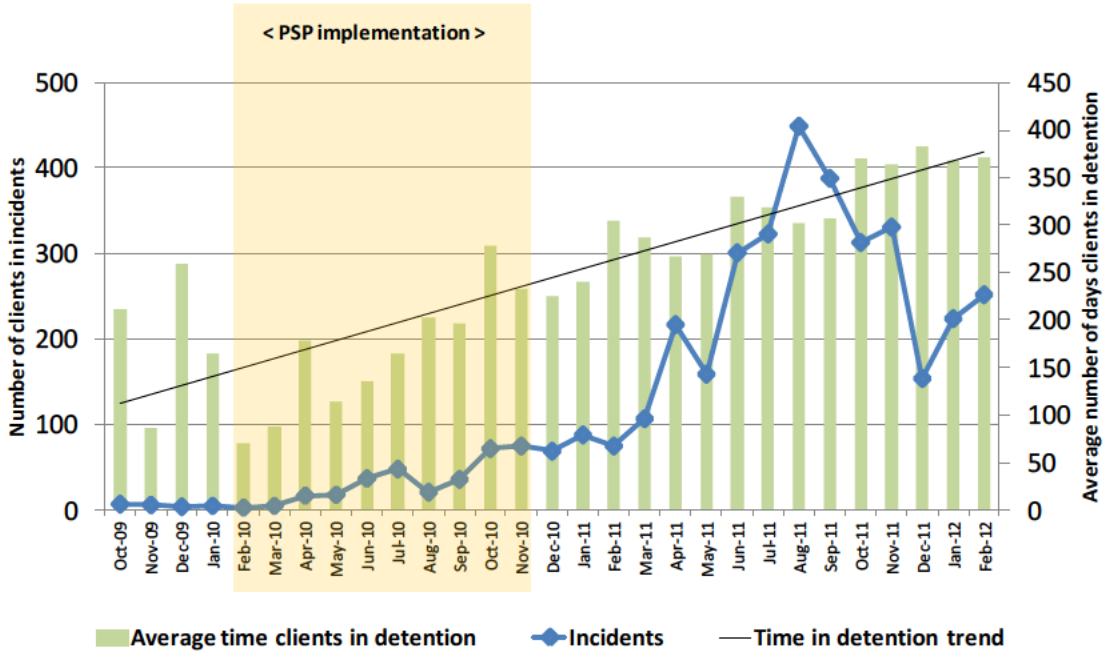


Figure 11: Reported incidents of self-harm and average time in immigration detention

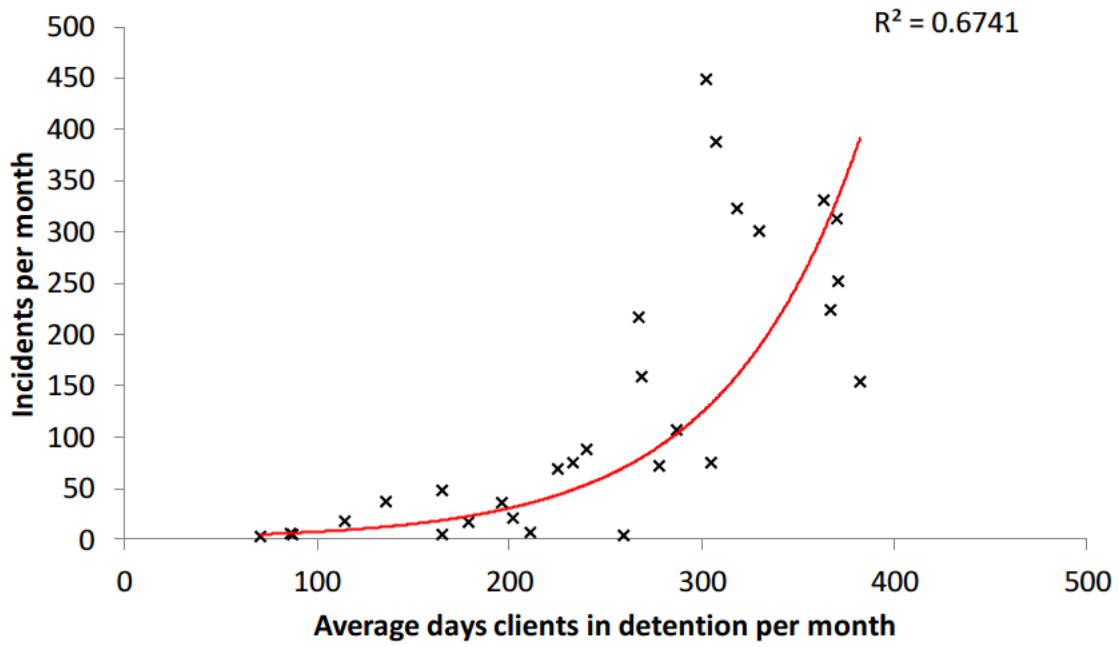
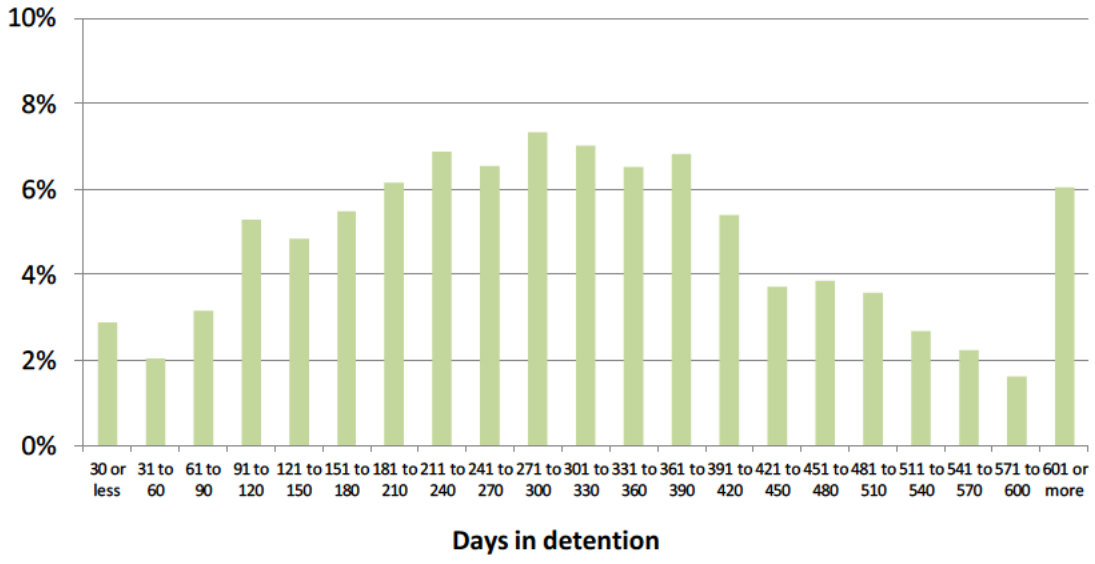


Figure 12: Reported incidents of self-harm by days in detention



The population of IDFs is influenced by a range of factors including the number of IMAs and the rate at which visas are granted. In 2012, the number of IMAs doubled from a total of 4,793 in 2011 to 4,788 for the first six months of 2012. While the rate of granting bridging visas increased dramatically from 107 in 2011 to 2,507 in first six months of 2012 (with 622 bridging visas being

granted to IMAs in June 2012 alone), this was not sufficient to off-set the rate of increase in arrivals of IMAs or the decline in the number of protection visas granted (from an average of 477 per month in 2011 down to an average of 308 per month for the first six months of 2012). The number of IMAs removed from Australia has been less than 100 per year for the last three years[64].

Recommendation 11: The quality of data reporting needs to be improved through the development of agreed data definitions and pilot testing of the reliability and validity of reporting to develop a robust measurement system. Data reporting should have clear links to performance monitoring and quality improvement systems within a monitoring and evaluation strategy.

5.3 Outcomes for staff

The aims of the PSP policy include the reduction of "the level of uncertainty and stress for staff in dealing with persons in immigration detention who exhibit self-harming and suicidal behaviour" (p 3).[65] This section provides information on staff confidence and skills in working with clients who may exhibit at-risk behaviour.

In the online survey, staff rated relatively highly their competency and confidence in dealing with at-risk behaviour. The areas that were rated lower related to the prevention of at-risk behaviour and development of protective factors for client's mental health (such as social engagement for clients). For IHMS staff, the need for a security escort, even in low risk settings, was seen by some as a limitation on their ability to build rapport with clients, to reduce the social stigma associated with mental health and use proactive engagement models with clients.

5.3.1 Competency to manage at-risk behaviour

In the online survey, staff were generally positive about their ability to communicate with other staff to gather information about at-risk behaviours (56% excellent/very good) and their ability to recognise at-risk behaviours (54% excellent/ very good) (Figure 13). At the site visits, staff often commented on the important role of Serco staff in identifying clients at-risk. This was particularly true for some cultural groups where the stigma on mental health was high, making self-identification of risk or need for mental health services low.

"PSP is only as good as the clients' ability opening up to somebody for us to notice the problem."

[64] Department of Immigration and Citizenship, 2012, *IMA Key Operational Statistics*, June 2012. Unpublished

[65] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.

"Serco staff are at the coalface, they are the ones best placed to notice."

"People who self-harm are not always the ones you'd identify as at-risk".

While still rated highly, staff were less confident in their ability to have their concerns about a clients' risk taken seriously (48% excellent/ very good). IHMS staff at site visits commented on a lack of training and over-referral by some Serco staff. This particularly related to confusing normal signs of grieving or distress (such as crying) with signs of mental illness or a lack of coping.

"'"If you see something of concern, tell people" This message has been pushed hard."

"I told the Serco staff to start worrying when he stops crying"

Staff were least positive about their ability to prevent at-risk behaviour (38% excellent/ very good). In interviews during site visits staff commonly mentioned that at-risk behaviour was a result of immigration visa pathway decisions and out of their hands to control. The PSP was seen as a risk management program rather than a preventative program. The use of the PSP at the time of an adverse immigration finding was the one area of prevention that staff identified.

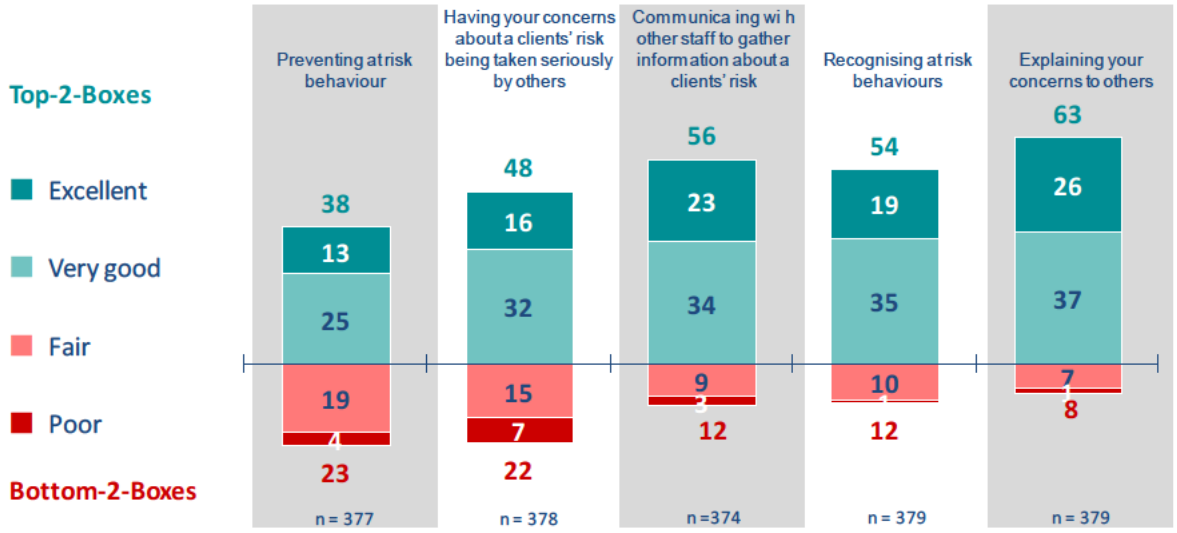
"PSP is about seeing them [clients] rather than caring for them."

"PSP is not a screening tool."

"It's tailored to the risk of harm rather than helping with the problem."

Across all ratings there was a tendency, though not significant, for Serco staff to be slightly less positive. While these rating of competency may be acceptable as a general benchmark, higher rates of competency may be expected if these attributes were used to measure training outcomes. This was not attempted in the online survey as the lag between the training and the measurement of training outcome was not known.

Figure 13: Competency in managing at-risk behaviour

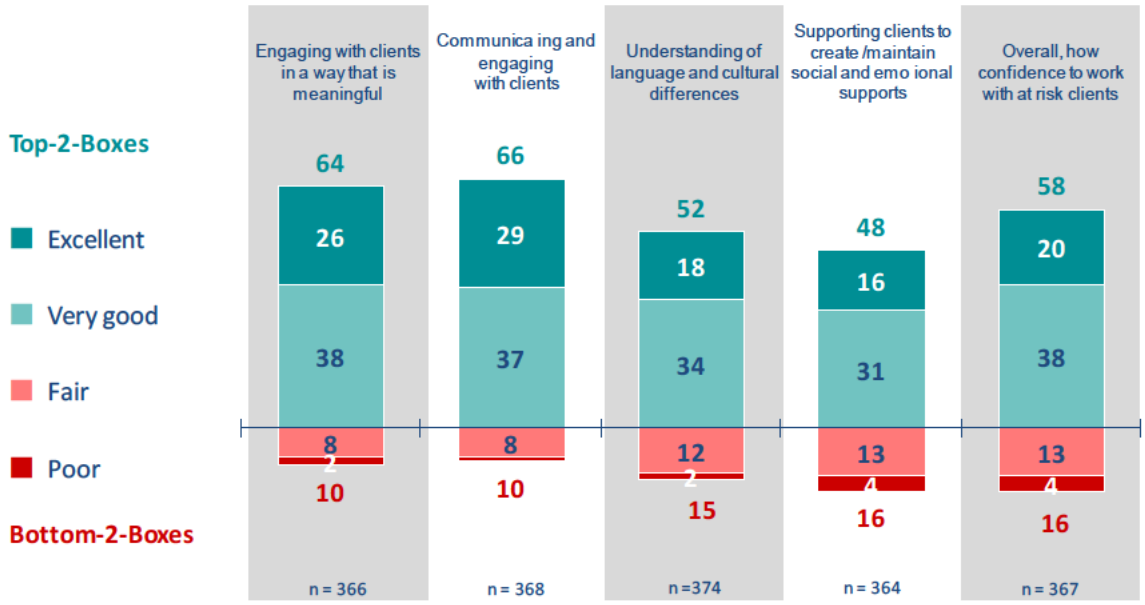


Base: All Respondents who
Q14: Thinking about the prevention of self-harm, please rate how competent you feel in the following areas...?

5.3.2 Competency to manage at-risk behaviour

Overall, staff responding to the online survey reported high levels of confidence (58% excellent/ very good) to work with clients who were at-risk (Figure 14). Confidence was particularly high for ability to engage with clients in a meaningful way (64% excellent/ very good) and communicating with clients (66% excellent/ very good).

Figure 14: Confidence in managing at-risk behaviour



Base: All Respondents
Q13: Thinking about the prevention of self-harm, please rate how competent you feel in the following areas...?

In site visits, some IHMS staff raised concerns about the separation of mental health services from the living areas of the IDF and the need for security escorts to visit clients in low risk settings. This meant the clients were stigmatised when they went to a clinic and the mental health team were not able to work with the IDF community to build awareness of mental health and develop rapport with clients outside of a clinical setting. These staff felt their meaningful engagement with clients, ability to provide outreach services and address the cultural stigma of mental illness would be enhanced by more freedom to access clients in their living environment.

"Some of these guys come from cultures with a real stigma in mental health. It's bad in Australia but other cultures have much stronger stigma associated with it. These guys will never come to you, you have to go to them and knock on their door."

"Breaking down the stigma of mental health is an issue."

In the online survey staff were also confident in their ability to understand language and cultural difference (66% excellent/ very good). During site visits, many staff spoke highly of their engagement with interpreters and how they could add insight to language and culture beyond straight translation. Life With Barriers was also seen as supporting clients well and providing insight to staff on cultural issues.

"The really good translators tell you about the tone and cultural meaning of what they are interpreting. The attitude. Cultural meaning of body language. It helps a lot in dealing with subtle things like depression that can lead to self-harm."

Staff responding to the online survey were least confident about their ability to support clients to make and maintain social supports (48% excellent/ very good). This is an important aspect of personal resilience to combat risk for self-harm. This also relates to the area of prevention where the PSP was seen to be very weak.

A

APPENDIX A: IDF CASE STUDIES

This section provides an in-depth view of the implementation of PSP in IDFs at two different settings:

- Darwin, including the Northern Immigration Detention Centre (NIDC), Darwin Airport Lodge (DAL) APOD (1, 2 and 3) and Wickham Point IDC
- Sydney, Villawood IDC.

Villawood Immigration Detention Centre

The Villawood IDC is located in Sydney's western suburbs. Villawood IDC mainly caters for people who have over-stayed their visa or those who had their visa cancelled due to compliance issues. It houses a small number of IMAs. People refused entry into Australia at international airports and seaports may also be detained at Villawood IDC[66]. As of March 2012, Villawood IDC has capacity to accommodate 379 to 480 people[67].

Since its early use as a migrant hostel in the 1960's and 70's when it was originally constructed, the buildings were upgraded to provide a secure IDC. In the 2009-10 Budget, allocation was made of $186.7 million to extensively redevelop Villawood IDC. The redevelopment included the replacement of the higher security accommodation with a new 90 room facility and new central facilities (kitchen, dining, medical, mental health, education, recreation and sporting facilities) and replacement of lower and medium risk accommodation blocks. In addition, disturbance at Villawood IDC in April 2011 resulted in damage to the some buildings. Work on the reconstruction is currently underway[68].

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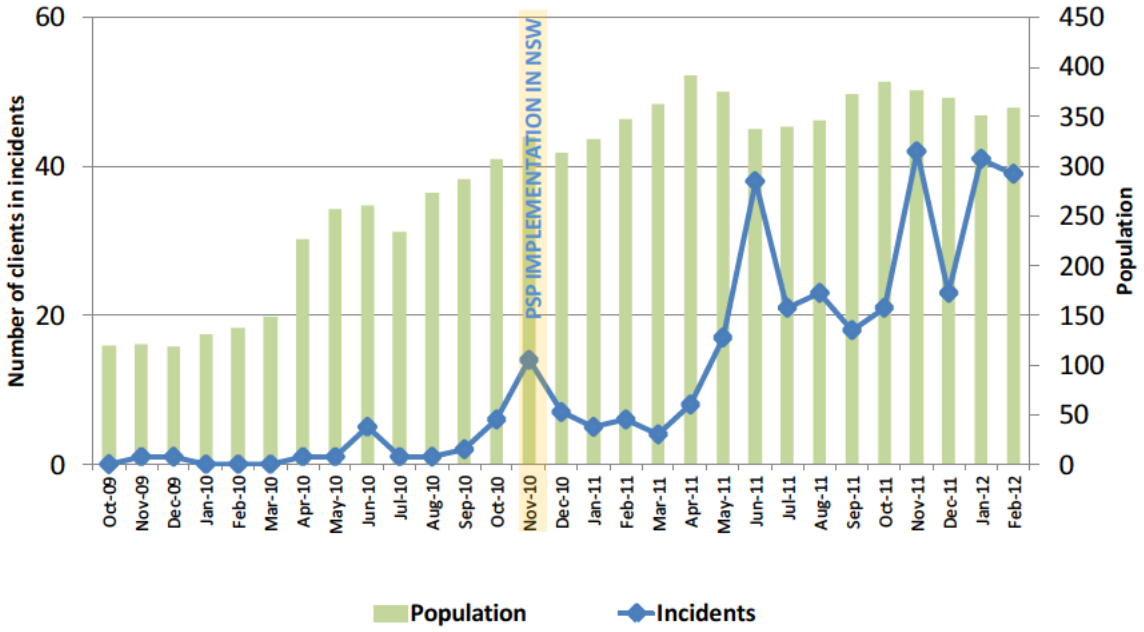
[66] Department of Immigration and Citizenship, *Managing Australia's borders: Villawood Immigration Detention Centre in Sydney (NSW)*. Available at: www.immi.gov.au. Accessed: 01/06/2012. Australian Government, Canberra.
[67] Australian Government Department of Immigration and Citizenship, *Managing Australia's borders: Accommodation Capacity*. Available at: www.immi.gov.au. Accessed: 01/06/2012. Australian Government, Canberra.
[68] Department of Immigration and Citizenship, *Managing Australia's borders: Villawood Immigration Detention Centre in Sydney (NSW)*. Available at: www.immi.gov.au. Accessed: 01/06/2012. Australian Government, Canberra.

Self-harm data

DIAC provided data on the reported incidence of self-harm in IDCs from October 2009 to March 2012. This information included some personal and environmental characteristics. Analysis of reported incidents of self-harm from clients at Villawood IDC revealed that there were 354 incidents, including actual self-harm (63 cases, 18% of incidents), threatened self-harm (255 cases, 72% of incidents) or attempted serious self-harm (36 cases, or 10% of reported incidents).

The pattern of incidents of reported self-harm at Villawood shows a similarity to the national pattern as described earlier, with increases in population size a potential lead indicator of increases in reported self-harm, with a few months lag (Figure 15). It is also apparent that reported incidents of self-harm increased at the time of PSP implementation and spiked subsequently.

Figure 15: Reported incidents of self-harm – Villawood (October 2009 to February 2012)



Training

There were high levels of awareness of the PSP amongst IDC staff consulted as part of the site visit, however the depth of understanding of the PSP amongst staff was variable. Many staff described the program as a risk management program, and this was particularly evident amongst operational staff who were involved in regular implementation of the PSP. Senior DIAC and SERCO staff were more likely to describe the program as broader than risk management in intention, however they expressed concerns that it was not delivering on these objectives.

Of those staff interviewed, many had participated in initial PSP training several years ago when the policy was first introduced; none reported receiving training since that time. Some staff indicated

that they expected 'refresher' training to be implemented soon, however the details of this were not known. While many staff referred to some form of training, some had had none. Several Serco staff referred to 'on-the-job' training, relating to the process of reporting 'sightings' as part of the supportive monitoring and engagement component of the PSP.

Training that had been undertaken by those interviewed was reportedly focussed on building understanding and awareness of mental health issues in detention broadly, and only a portion of the training was specifically about the PSP procedures. Staff generally thought the training was useful, however DIAC and Serco staff who had attended the training commented that it was very high level and policy focussed, and did not address staff skills or competencies, nor issues such as how to implement the policy. IHMS staff were less likely to consider this a concern, reflecting their perspective that IHMS were responsible for implementing PSP more so than DIAC or Serco staff and had a health professional background to drawn on.

"We talked about PSP [in the training] *but not how it actually works at the centre."*

"Staff skills and backgrounds vary so it's not always appropriate for them to be developing implementation themselves."

"We had to submit a PSP process plan, but this was a tick-the-box exercise."

While staff expressed a wish for more specific training relating to the implementation of the PSP at Villawood IDC, the broad mental health awareness aspect of the training that had been delivered was regarded as valuable. One staff member who had implemented the SASH program prior to PSP, had 'recognition of prior learning' granted and on these grounds did not attend PSP training.

Access to mental health services

Access to community services was not considered problematic at Villawood IDC. However, very few clients were reportedly referred to external clinicians through PSP (or indeed generally); issues were managed by IHMS staff on site during the hours they were present. After hours (5pm – 9am) the nurse triage line was used to seek advice on any arising issues. If a client was seen as at-risk of self-harm, they were routinely placed on KeepSafe as a risk management procedure until IHMS staff were available the following business day. It was reported that accessing appropriate mental health clinicians through the triage line could vary, and at times callers were placed on hold for up to an hour. Advice provided by this triage telephone line was used to determine which level of KeepSafe the client would be placed on overnight.

"You can call a nurse, but you need to get to the right person [with appropriate clinical experience]*."*

Clients from the residential unit at Villawood IDC were commonly referred to community mental health services as they did not have formal access to IHMS services. However, it was anticipated

that the completion of the new medical facilities onsite would allow residential clients to access IHMS services as a first point of referral.

After-hours access to mental health care was considered a major gap by both Serco and IHMS staff. In particular, the hours which IHMS staff were present on site was seen as often inadequate to see all referrals on the day in which they were made. Further, it was consistently noted that the hours of IHMS presence onsite were not well aligned with typical client activity, with many clients sleeping through much of the day and waking in mid or late afternoon (and this pattern was able to be observed whilst on site). As a result of this common pattern, there was often a spike of referrals after 4pm when issues would first be presented. Referrals made after 4:30pm were often not seen until the following business day.

"We get a lot of issues late afternoon. A 24 hour [IHMS] *presence would be ideal."*

"We get referrals at 4:30 or 4:45 almost daily."

While new mental health facilities were under construction at Villawood IDC, the current facilities used by the IHMS staff were cramped, and presented a challenging environment in which to provide mental health services. With the completion of the new facilities, further preventative activities such as group relaxation therapies were planned.

There was limited referral to external clinicians reported by IHMS staff, for either treatment or diagnostic issues.

Communication and coordination

Stakeholders from DIAC, Serco and IHMS consistently stated that the PSP had improved communication between agencies. While there remained some frustrations related to the channels for sharing information, and the value of information that was shared, nevertheless the improvement to collaboration between agencies was seen as the hallmark of the program compared with previous programs.

"Communication between stakeholders has improved immensely."

While stakeholders now felt that they had formal mechanisms for sharing information (through the observational reports, incident reports and daily meetings), there was a view expressed that many staff were 'burnt out'. This resulted in a degree of resignation or jadedness regarding the motivations of sharing more information and whether it was in the clients' best interest.

About the clients on PSP

Formal communication was almost entirely limited to information shared at the daily meeting. This meeting encompassed a range of issues, with PSP issues typically discussed in a few minutes at

the start of the meeting. Information relating to PSP was seen to be limited to an update regarding who was 'on' or 'off' the program, and information about the level of supportive monitoring and engagement that was required.

"We need to be proactive to understand clients, but the PSP list doesn't give any details about how to work with clients."

"We don't get information [about clients] *unless we ask for it, and we never get information about clients who are not on the* [PSP] *list."*

"Is the design of the daily meeting right? We get a quick and dirty synopsis. Is it the right forum for PSP discussions?"

The daily meeting was seen as useful by the executive who attended, however several of these managers noted that for them to make decisions about clients they needed input from their operation staff who were interacting with clients regularly, and so they often felt poorly placed to be making on the spot decisions. Conversely, operational staff who did not attend these meetings felt that without having access to the client-focussed discussions that took place in these sessions, they were limited in terms of their ability to think on their feet when engaging with clients. As such, staff saw a gap in vertical communication within agencies relating to the client information sharing at daily meetings.

There was also information sought about client's mental health status and support needs after a period of supportive monitoring and engagement. Several stakeholders within IHMS, Serco and DIAC saw a need for a step-down process for clients after supportive monitoring and engagement ceased.

It was also reported that clients would not always know they were on a supportive monitoring and engagement plan. IHMS staff would make a determination as to whether it would be constructive or not for the client to be made aware that they were on a plan. Some Serco staff felt that this practice was problematic as clients would be distressed about being monitored without knowing the reason for the monitoring.

Between Stakeholders

Communication between stakeholders was seen to be improved. However it was consistently noted by DIAC and Serco staff that they encountered limits to the information about clients shared by IHMS staff. IHMS staff stated very clearly that to share any information about clients beyond whether or not they were placed 'on' or 'off' PSP would be a breach of confidentiality with their client. This position appeared to contribute to the crude understanding of PSP as an 'on' or 'off' program by other stakeholders, as they had little insight into support and engagement activities beyond monitoring associated with a PSP risk level.

IHMS staff felt that the information they received from other stakeholder organisations was satisfactory for them to perform their role. However, Serco staff felt that they were unable to provide care for clients without having some insight into their wellbeing, and that the lack of information about clients' mental health hindered their ability to manage clients safely and appropriately at times. Some DIAC staff expressed concerns about their own safety if they were unaware of particular issues a client may be experiencing. Information that was sought by Serco and DIAC staff included information relating to the types of mental health conditions experienced by individual clients and unusual behaviours that may be associated with these, advice on the most appropriate way to interact with the client, and information about whether treatment was being received by the client more generally.

Case management

Case management by DIAC was limited to issues relating to visa pathways. Most case managers would see clients on a monthly basis on average. Within IHMS it was reported that client case management would occur, however a multi-agency approach to case management appeared to be limited to discussions occurring at daily meetings to inform decisions about risk levels of clients.

Policy integration

PSP did not appear to be well integrated with other policies. KeepSafe was seen as interchangeable with PSP by many within Serco and DIAC, and KeepSafe was consistently used where a client was referred to PSP after-hours and waiting to see an IHMS staff member the following day. It was also reported that a single client may in fact be monitored through multiple different programs (such as PSP, KeepSafe or SecurityWatch), and while this was acknowledged as somewhat invasive, it was seen as an inevitability of how the various programs were designed and the lack of coordination between them.

"There should be a process to take them [clients] *off KeepSafe if they're on PSP."*

"I feel reasonably confident that PSP and KeepSafe don't let people slip through the cracks. But the policies don't line up at all."

Some Serco and DIAC staff were also concerned that they would have no information about a client's mental health if they received mental health treatment by IHMS without being on a supportive monitoring and engagement plan. Staff reported that this had resulted in referrals for conditions that were already being managed by IHMS. Further, if such a referral did not result in a supportive monitoring and engagement plan, Serco staff would at times place the client on KeepSafe monitoring as a precautionary measure (although this was at odds with the assessment of IHMS staff). These incidents appeared to be the result of a lack of communication and role clarity between agencies.

Practicality of PSP design

The design of PSP and its subsequent implementation was seen to work well when viewed as a purely risk management program. Staff who felt that the program was supposed to do more than just risk management considered that there were some inadequacies in the implementation of the program. Staff who had worked at other centres felt that PSP was implemented differently at different centres (mostly around when staff would meet and discuss cases, and what information they would discuss in relation to the client).

It was suggested by a few staff that the PSP was designed for an IMA population (and in consideration of the ethnic and cultural traits of this population) and that it was not appropriate for a large proportion of the Villawood IDC population who did not fit that description – both for cultural reasons and due to detention pathways. In particular, it was suggested that the success of the PSP was often dependent on clients' ability and willingness to make known or display mental health issues, and it was noted that amongst some ethnic populations there was far lesser likelihood of mental health duress being publicly displayed due to cultural norms.

"It fits on Christmas Island but nowhere else."

Preventative care/ environmental modifications

There was little sense amongst staff interviewed that the PSP functioned as a preventative program; only a few senior staff indicated that the PSP was supposed to act as a preventative program. While operational staff did not see an issue with this, more senior staff expressed concerns that the PSP was not address these broader needs.

"It doesn't do what it says on the tin."

"The ideal would be case conferencing with all agencies and including clients, to set milestones and goals, enhance coping mechanisms, counselling support...."

"PSP doesn't fix issues, it's just a tool for us to keep people safe while they're here."

"PSP is reactionary mostly. There is other preventative stuff happening."

Meaningful engagement with clients as part of supportive monitoring and engagement plans did not appear to be seen as part of PSP, with the program interpreted as requiring observational monitoring by Serco only (in addition to treatment delivered by IHMS staff).

According to some IHMS staff the PSP was used alongside preventative health measures and programs that support wellbeing, and does not necessarily replace these. However, it did compete for limited time and resources. It was also not clear to many of the DIAC and Serco staff consulted, as to whether clients who had been referred to IHMS due to concerns that they were at

risk of self-harm were receiving any treatment or psychological support, since this information was generally not shared with staff outside the IHMS. The assumption was that clients were simply being monitored.

While some staff were reassured by the 'black and white' interpretation of the program as simple reporting and auditing of monitoring, others expressed that the focus on record keeping had become the sole focus at the expense of using common sense and compassion when dealing with clients.

"It's a very black and white policy. It makes it stronger; there are clear clinical guidelines."

The temporary medical facilities available for providing mental health care at Villawood were limited and not considered to be well suited to a mental health care environment. New facilities were expected to be completed within a few months. Once the new medical facilities are available there are plans by IHMS to run group counselling and other preventative and support sessions, not just for those on PSP but for anyone with a need.

"IHMS are really short on resources."

Assessment and referral

Referral to IHMS staff for PSP assessment was seen to be able to be done by all staff, however was reported to be almost exclusively done by Serco staff. Assessment of clients was conducted by IHMS staff at their earliest availability (often not the same day) and external clinicians were not reported to be referred to or involved in client assessments by those IHMS staff consulted.

When determining whether to make a referral, staff across agencies consistently stated they would err on the side of caution and refer a range of behaviours including:

- Erratic behaviours
- Threats of harm
- Sporadic or out of the ordinary behaviour
- Apparent confusion in a client
- A change in appearance
- Verbal statements about how they are feeling
- Receiving bad news

- If they've a prior history of issues.

Behavioural and psychological issues

Those IHMS staff consulted as part of the site visit were clear that they do not use PSP for 'behavioural' issues; 'behavioural' issues were referred to as issues relating to protest behaviour or advocacy to influence positive visa outcomes or placement decisions. Some IHMS staff considered that most issues that lead to PSP referrals related to not knowing about visa outcomes rather than mental health issues. Many IHMS staff acknowledged that the management of 'behavioural' issues was a gap, however it was seen as a disciplinary and asset management issue that was managed by Serco through the Keep Safe program.

"There are no options in PSP for managing other issues."

"If someone presents as harming but there is no mental health presentation, then they will be put on KeepSafe."

"We've had KeepSafe prevent harm for a client who was refused PSP."

"It's a big issue for us. I would argue that any self-harm is a mental health issue. It's a very difficult area."

Supportive monitoring and engagement

Supportive monitoring and engagement (for high imminent and moderate) was limited to visually 'sighting' the client and recording the sighting and a brief description about what the client was doing on a PSP reporting sheet. The implementation of PSP and KeepSafe were seen as interchangeable to the degree that Serco staff would use the same form to record client monitoring and simply check a box to indicate whether the client was on PSP or KeepSafe.

Some IHMS staff also reported frustration at the inflexibility associated with the three levels of PSP.

"Sometimes a client's risk doesn't fit the levels. There's no flexibility in the policy."

The shared dormitory facilities were seen as problematic by some staff from both IHMS and Serco, in relation to the requirements for monitoring, as observations often resulted in disturbing not only the person being monitored but also any clients they were sharing sleeping facilities with. Some clients were reported to have complained about night-time disruptions to their sleep as a result of program monitoring. Some IHMS staff felt that disturbances were due to lack of staff training in how to monitor. However inspections of the facilities demonstrated that there was little scope for conducting monitoring at night without needing to enter a room. Serco staff who were conducting the observations acknowledged the potential for these to be disruptive but saw this as an

inevitability given the program's design. The alternative, of removing clients on high risk imminent risk to an isolated unit for observation, was considered harmful and not recommended in most circumstances by either IHMS or Serco staff interviewed. A separate unit was available for those who required high imminent supportive monitoring and engagement through the PSP, and this unit was also used for other purposes on site. This unit included 24 hour video surveillance.

Local adaptations or extensions to PSP

The PSP policy was implemented *"by the book"* at Villawood with observations occurring at fixed intervals. Many Serco staff felt that this was problematic – an example was provided of a self-harm occurring five minutes after an observation as the client knew they would not be observed again for an hour. However the prospect of implementing the program differently had not been considered permissible by these staff. It was suggested that having greater flexibility around observation levels would be beneficial.

Some staff felt that the levels of observation were too rigid and could have negative consequences for clients. It was felt that high imminent monitoring throughout the night could disrupt sleep patterns and exacerbate clients' stress and anxiety, however removal to other facilities, and isolation from friends and family, could also create distress.

Site visit: Darwin Immigration Detention Facilities

The Darwin site visits included the following locations:

- Northern Immigration Detention Centre (NIDC) was constructed of new and reused portable buildings following the decision announced in August 2001 to establish contingency centres. The facility was located within the fence line of Defence Establishment Berrimah[69]. NIDC has capacity to accommodation 446 to 504 people[70].

- Wickham Point IDC is a new, purpose build compound that has capacity to accommodation 500 to 1000 people[71]. After its completion, it will accommodation up to 1,500 people. Wickham Point IDC was constructed primarily to accommodate adult males who arrived as IMAs.

- Darwin Airport Lodge Immigration Detention Centre (DAL) is an APOD that includes three sites. Across these sites DAL accommodations 435 to 585 people[72].

Self-harm data

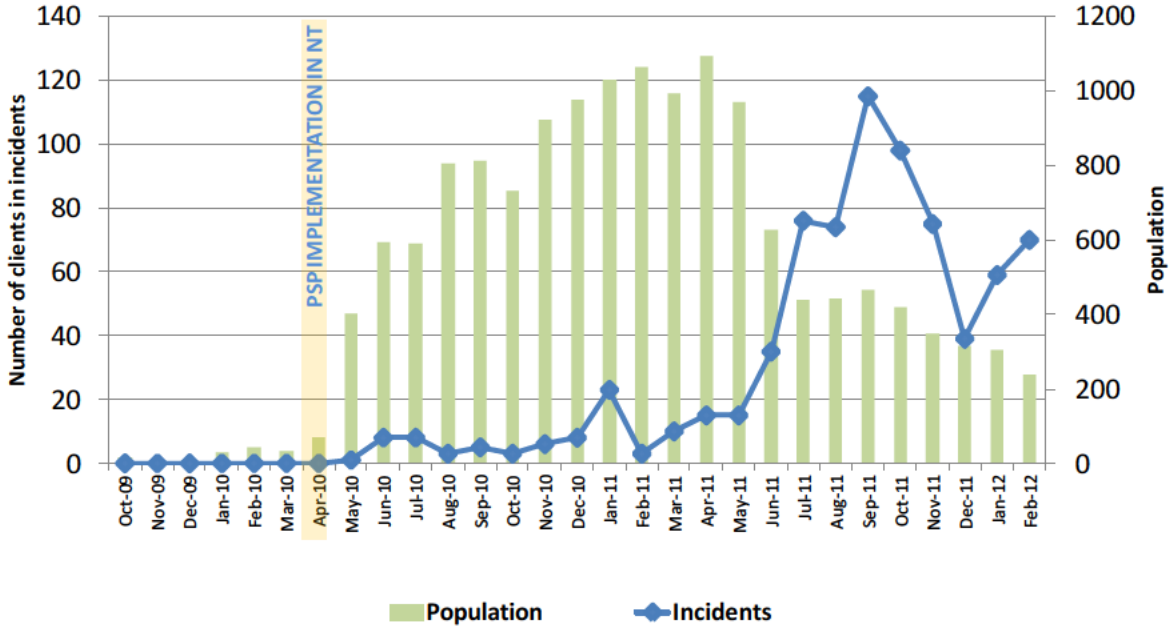
DIAC provided data on the reported incidence of self-harm in IDFs from October 2009 to March 2012. This information included some personal and environmental characteristics. At the detailed level of analysis, this data was only provided for NIDC.

Analysis of reported incidents of self-harm from clients at NIDC revealed that there were 754 incidents, including actual self-harm (303 cases, 40% of incidents), threatened self-harm (422 cases, 56% of incidents) or attempted serious self-harm (29 cases, or 4% of reported incidents).

The pattern of incidents of reported self-harm at NIDC shows clear trend between population size and self-harm, with a lead effect of several months (Figure 16). It is also apparent that reported incidents of self-harm increased only slightly after the PSP implementation and appear to be more related to population size.

[69] Department of Immigration and Citizenship, *Managing Australia's borders: Northern Immigration Detention Centre at Darwin*. Available at: www.immi.gov.au. Australian Government, Canberra.
[70] Department of Immigration and Citizenship, *Managing Australia's borders: Accommodation Capacity*. Available at: www.immi.gov.au. Accessed: 01/06/2012. Australian Government, Canberra.
[71] ibid.
[72] ibid.

Figure 16: Reported incidents of self-harm – Northern IDC (October 2009 to February 2012)



Training

There were high levels of awareness of the PSP amongst IDF staff, however the depth of understanding of the program, both in terms of the policy intent and from a procedural perspective, was variable. Many IHMS staff were familiar with the PSP policy, and this was often attributed to both their clinical training and engagement in the implementation of many aspects of the policy. Staff consulted from DIAC and Serco reported that the vast majority of their understanding and knowledge of the PSP was built through their work rather than through training.

"We know the channels we have to go through and do that. We learn that on the job."

"I've done it [the training] *three times and I learnt something new every time."*

Most staff interviewed reported they had had some form of training. Although staff across all agencies demonstrated their awareness of the importance of managing the risk of self-harm and suicide, many of the non-clinical staff report limitations around their understanding of the PSP and its implementation despite having received training. Where issues were reported by some staff, these chiefly related to perceptions of the availability, access and level of training provided as barriers towards improving their understanding of the policy.

"What is a warning sign? We need more support to recognise what is a mental health issue."

"I haven't seen it [training] *in a year and a half."*

"When we started we got training; that was alright."

Some staff commented that the PSP training provided had a high level policy focus. Whilst an understanding of the policy was considered important, it was not seen to equip them for involvement in the delivery of the PSP. Overall, concerns that were reported by some staff regarding the training related to the perceived relevance, rather than the quality, of training.

"The training is very theoretical."

"The training isn't very helpful...it's fairly non-specific."

"The PSP policy document doesn't mean anything to non-clinical staff."

Some Serco staff reported concerns about existing levels of knowledge and competence to identify mental health issues, given their ongoing role in supporting clients and lack of clinical training, particularly at times when IHMS staff are not available on-site. Many DIAC case managers, on the other hand, reported that their role focused on achieving an immigration outcome. As such their concerns centred more strongly around the need for effective communication regarding a clients' risk so that this could be considered as a factor in communicating with them. For example, if a case manager was a aware that a client was at risk, they would try to reduce the waiting time between notification of a meeting and the appointed time to minimise any anxiety for the client.

Of the staff consulted during the site visit, some had received training during the initial role out of the PSP and no further training; others had last received training a year and a half earleir; and a few had recently received training as part of their induction process.

Some staff commented that the frequency with which training was delivered did not reflect the high level of staff turnover and mobility within the detention network. It was suggested that training should be delivered on site every 3-4 months, bundled with other forms of training (e.g. first aid) and ideally a requirement of re-accreditation/refresher training. A few non-clinical staff reported a lack of access to training and that resourcing constraints could make it difficult to attend training.

"...ongoing programs would be beneficial so we remind ourselves of behaviour patterns and triggers, that would be great".

"[Self-harm and suicide] *is an ongoing issue so the better equipped you are, the better."*

Access to mental health services

Access to mental health services was perceived to be good during the day-time when IHMS mental health staff were on-site. There was variation across the Darwin sites visited with regard to the on-site mental health services and supports that were available outside these times; access was, however, typically seen to be poorer at night and weekends. The absence of on-site mental health support services after-hours was raised by many staff as an issue given that many clients are typically awake during the night time and often sleeping during the day when mental health staff are on duty.

Access to community mental health services was considered problematic by staff. Local services were seen as already under stress and reluctant to support clients who had access to alternative mental health treatment that better understood their experiences and care needs. Some staff also considered it advantageous for clients to see a mental health clinician with whom they had some continuity of care, and existing rapport. Community services were seen more as after-hours emergency management when IHMS was not available.

"There is a continuity [of care] *issue in exposing clients to different people...it may be better to do an assessment every two days by some person than by a different person every day."*

DIAC and Serco staff consulted typically reported that they were familiar with options for reporting/escalation procedures that applied during hours when IHMS staff were not on-site (e.g. that they should call the duty phone). Awareness of the Nurse Triage and Advice Service available for after-hours mental health advice was high amongst the staff consulted during the site visit. There was also high awareness of a piloted being conducted at Wickham Point IDC with the IHMS mental health team to provide mental health support and after-hours site visits. The pilot was perceived to be offering a valuable alternative to the Nurse Triage and Advice Service for this remote location. The mental health clinician on call determines whether an on-site assessment is required, or to provide advice remotely if appropriate.

Some staff expressed concerns that the Nurse Triage and Advice Service did not provide sufficient support as the available clinician did not necessarily have mental health experience.

All staff reported good access to mental health services for clients during IHMS on-site operating hours (which varied across the sites visited).

Communication and coordination

Many staff reported that the introduction of the PSP had brought significant improvements in communication between agencies, and the coordination of services provided to clients in the management of self-harm/suicide risk.

"The communication that PSP opens up is much more effective."

Some staff felt that communication and coordination was focused on clients at high imminent risk of self-harm and/or suicide. Others suggested that effective communication was often reliant on good working relationships between stakeholders rather than on formalized channels, and a few raised issues surrounding ownership of communications and integration with other policies/programs.

About the clients on PSP

Communication was seen to be most effective within regular case management meetings. Daily reporting was provided by IHMS regarding those at high imminent risk. Many staff reported that documentation for people on high imminent monitoring was good and working well.

Some DIAC case managers stated that it could be difficult for them to easily identify if their clients had been assessed as at-risk as the structure of PSP information shared meant that they could only view all clients who were at high imminent risk at a single point in time.

"There is no notification [to case managers] *that comes when they go on/off PSP".*

Between stakeholders

Daily meetings to discuss clients on the PSP were the main channel for inter-agency communication. However some staff expressed concerns relating to the effectiveness of the communication exchange at these meetings, with the communication flow often seen as being uni-directional. There were seen to be confidentiality issues from an IHMS perspective that restricted the sharing of information about clients with Serco and DIAC attendees; rather it was reported by some that PSP discussions tended to focus on the provision of information about clients from Serco and DIAC to IHMS. Some Serco staff felt that it was difficult to safeguard client welfare without 'complete' information regarding their mental health.

A few staff members at one site stated that communication was improved more though informal information sharing that takes place between IHMS and Serco Welfare Service directly, rather than through the formal channels provided by the daily meetings.

"The [PSP Team] *meeting* [is] *more of a tick box because of contractual arrangements."*

"We are meant to have a PSP conference that in reality never occurs…I don't see the relevance of discussing with non-clinical people…it delays things when you want to put them [the client] *on PSP."*

"Who has ownership of the communications?".

"Communication happens all the time, that's fantastic, we share crucial information and that really does work."

"Communication is too loose; you're relying on a good relationship for them to come and tell you things."

A further area of concern for some staff was the step-down process from PSP. These staff felt that the fact that clients were no longer identified as at risk left them without a needed tool to actively manage and monitor some clients, particularly where there was no transparency around the decision to change the client's status.

"When they're [clients] *taken off PSP, where does that leave us?"*

"Once clients are taken off PSP, they're not on the radar anymore".

Case management

Some staff from each agency reported case management activities performed by their agency; for DIAC and IHMS these activities were seen to relate to managing client welfare and risk, they were not seen as part of the PSP. For IHMS activities related to broader management of clients' treatment and care, for Serco case management was conducted as part of a Personal Officer Scheme to promote clients' health and wellbeing, and for DIAC case management pertained to a client's visa pathway.

Policy integration

It was consistently reported by staff during interviews that clients were routinely placed on KeepSafe as a stop-gap measure, until they could be assessed on-site during hours when mental health services were available.

Further, it was reported by some Serco staff that a client may be monitored through multiple programs, and this was often seen as problematic by these staff. For example, a client may be placed on watch under KeepSafe, Security Watch and the PSP. A few Serco staff who were familiar with both KeepSafe and the PSP suggested that the KeepSafe policy was better supported with associated resources and documentation, and thus it was perceived as a more valuable tool by these staff.

"Communication and linkages with other policies are the issue".

"KeepSafe is a bit more of a care plan, it's got activities."

Practicality of PSP design

A number of challenges were reported by staff regarding implementing the PSP in the detention environment. Broadly, these challenges related to the limited capacity to modify the physical detention environment to ensure inline with the PSP policy. Some staff who worked across sites also noted that implementation of the PSP varied from site to site.

"There's a gulf between the policy and implementation on the ground. It constantly changes [between sites]*."*

Preventative care/ environmental modifications

Some staff reported difficulties in implementing the environmental modifications necessary to minimise risk, particularly where there were accommodation capacity issues or where a larger number of clients shared a room, and in making congregate areas safe. It was reported that actions such as removing items from a clients' environment required a level of approval from a more senior staff. Some staff also felt there was potential for stigmatising clients by moving them to safe accommodation.

"Serco are not allowed to remove things like razor blades without senior staff approval."

"The high dependency room is in an area of high activity...it's not conducive, everyone can see the client."

Recreational activities were provided across sites that were visited. At some sites this included group sessions dealing with topics such as culture, rights, parenting groups, expectations about life in Australia, stress reduction strategies, art therapy and an activities schedule including excursions. A few staff reported difficulties in engaging clients in these programs (particularly at certain sites/cohorts) and the fact that client activity is often greater at night time whilst these activities are scheduled during the day time. Some Serco staff reported resourcing delaying implementing the Personal Officer Scheme which provides a key worker system for clients.

"The Personal Officer scheme, we're trying to get it up and running; it's very difficult to implement in certain centres. There's a resourcing issue".

Behavioural and psychological issues

Many non-clinical staff reported difficulties in recognising the risk factors for self-harm and suicide and they felt they did not have sufficient training to distinguish between behavioural issues (e.g. protest behaviour) and other clinical mental health issues. As such, these non-clinical staff stated that they would refer any clients thought to be potentially at risk for IHMS assessment. Examples of reasons for referral that were provided by staff during the site visited included: if they noticed anything that was not typical behaviour for the client, if they were aware of an incident or an

immigration outcome/decision that was imminent (or has occurred), if they were aware of a family death, if the person was seen crying, and purely on 'gut' feeling on the basis of their rapport with the client.

Amongst IHMS staff there was some variability reported regarding whether 'behavioural' motivations were regarded as within the scope of the PSP or considered a separate non-clinical issue.

"A lot more can be done on training on behavioural issues."

"Sometimes it's hard for a range of stakeholders if someone is at the point of developing a problem and they don't fit in the box [PSP risk level]."

Supportive monitoring and engagement

The views of IHMS staff consulted during site visits relating to supportive monitoring and engagement varied to include those who felt that the fixed monitoring scheduled associated with risk levels provided good clarity, whereas others felt that it restricted their clinical judgement. Where greater flexibility was sought, this related to options for specifying an approach to supportive monitoring and engagement to minimise disruption to the client (and any others they might be sharing accommodation with) to a degree that was appropriate to their level of risk.

"The lack of flexibility in PSP categories [is an issue] *the level of monitoring should be more suited to client needs."*

Some Serco staff reported that they would approach supportive monitoring and engagement plans with some flexibility at their own discretion, or because of practical issues with maintaining the schedule. Issues that were cited included the size of the sites and number of rooms, which in some cases meant that it might take half an hour to find the client before being able to 'sight the client' as part of a moderate supportive monitoring and engagement plan, whilst also being required to conduct a variety of other duties. Some staff reported that arms length requirement for high imminent supportive monitoring and engagement was often not implemented when the client was seen to require privacy, such as bathing or going to the toilet.

"Super close supervision can be quite irritating as well...it can make you act out even further in certain cases."

"One on one monitoring means there is less staff available to offer excursions."

A few staff felt that ongoing supportive monitoring and engagement could occasionally become problematic, as clients would potentially become accustomed to the additional amount of support they got when assessed at a particular level of risk and if they were no longer at risk, it may create a perverse incentive to engage in at-risk behaviour(s).

Review procedures

Some IHMS staff reported that it was not always appropriate to review clients at high imminent risk every twelve hours. An example given was that if a client is reviewed at 4pm, they would not recommend waking the client at 4am in order to conduct the review. In addition, the requirement for the review to be conducted at these intervals was seen to potentially disrupt the continuity of a client's care with a particular clinician, as that clinician would not always be available at those intervals.

"The twelve hour review is extremely difficult to implement...if the client is sleeping, you don't want to wake them up for the review."

Local adaptations or extensions to PSP

Some staff reported that the PSP was on occasion used to provide supportive monitoring and engagement not just for clients at risk of suicide and self-harm, but also for clients who were considered potentially vulnerable (for example, due to a pending visa outcome decision, sexual harassment, mental health issue, etc). Across all sites visited, many IHMS staff emphasised the difficulty in enhancing protective factors in the detention environment. Given this challenge, the PSP was seen as one of the few tools they had available to increase resources to provide support to clients.

"It would be great if it were used as a Psychological Support Program. There are a lot of vulnerable clients who are on PSP and many who aren't. Don't wait until they say they want to self-harm [to put clients on the PSP]".

"We certainly do put clients on [PSP] *for a little bit more assistance."*

IHMS staff reported having refined their procedures and case management so that all clients were seen as quickly as possible and that they are well supported within their own organisation in terms of psychiatric consultation and capacity to refer.

"We set up a triage service with Serco to reduce stress for clients so that they don't turn up expecting to be seen straight away."

B

APPENDIX B: MODEL REVIEW OF SELF-HARM AND SUICIDE IN DETENTION FACILITIES

The purpose of this model review is to examine approaches to the minimisation of self-harm and suicide in detention and correctional settings. The objective is to provide context to the Psychological Support Program and examine best practice approaches to harm minimisation with a view to helping identify alternative processes and practices that may help the PSP address any gaps or barriers identified by the evaluation and show how other similar programs have overcome challenges.

This approach was undertaken to the review given the uniqueness of immigration detention practices in Australia, in terms of policy setting, context and approach[73], and the consequent absence of comparable models in immigration detention settings globally. As indicated in the PSP policy '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[74]'.

The focus of the model review is on correctional settings, as they represent a similar setting of 'controlled environment' where people are 'involuntarily detained[75]'.

[73] '[Australia] is the only country in the world to enforce mandatory and non-reviewable detention for asylum seekers who arrive without a valid visa' in Skulan, C., 2006, *Australia's mandatory detention of "unauthorized" asylum seekers: history, politics and analysis under international law*, Georgetown Immigration Law Journal, p.65, Vol: 21.
[74] Department of Immigration and Citizenship, 2012, *Detention Services Manual (DSM). Chapter 6: Psychological support program (PSP)*. p.4. Stakeholder and Health Strategies Section, Detention Health Services Branch, Detention Infrastructure and Services Division, National Office. Australian Government, Canberra. Unpublished.
[75] Department of Immigration and Citizenship, 2007, *Detention Health Framework – A policy framework for health care for people in immigration detention*, p.41. Available at: www.immi.gov.au. Accessed: 13/05/2012. Australian Government, Canberra.

Research methodology

Models for inclusion as case studies were selected after an initial review of literature and discussions with DIAC. The case studies presented in this section are structured as follows:

1. **Introduction** outlining the policy context, program development and governance;
2. **Service delivery** including delivery methods, program content and staff training;
3. **Similarities and differences** detailing the ways in which the delivery model is comparable (or substantially varies from) the PSP.

Case studies were developed from review of the following publications:

- Official government publications (that is, research reports and summaries, data collections and policy publications) provided on websites;
- Academic and peer reviewed journal articles;
- Publications by stakeholder and other advocacy organisations;
- Press articles.

Suicide and Self-Harm (SASH) Prevention

Readily accessible information with regard to Suicide and Self-Harm (SASH) Prevention in the public domain appears largely confined to the reporting of issues surrounding its implementation, for example issues surrounding the levels of observation under this policy. Monash University was commissioned to conduct a review of the SASH protocols in 2008[76], the findings of this review are not publicly available. Consequently there are limitations surrounding reporting on the governance of the program overall, implementation and staff training.

The operational procedures/guidelines are described in further detail below followed by a comparison of similarities and differences between SASH Prevention and the PSP. The operational procedures outline:

- the processes around assessment of risk, referral, supportive monitoring and engagement, review, step-down/removal;
- governance, audit and multidisciplinary care team arrangements;

[76] Detention Health Advisory Group, 2008, *Report against 2007-08 work program*. Available at: http://www.immi.gov.au/. Accessed: 13/05/2012.

- staff competencies including stressors/risk factors; and
- information around who should be trained and when booster training should be provided.

Introduction

SASH Prevention procedures (also referred to as SASH OBS and SASH Watch[77]) was the system for the management of the risk of suicide and self-harm implemented in immigration detention prior to the introduction of the PSP in 2010 and was developed as a 'tool for non-experts based in a corrections environment[78]'.

SASH Prevention aimed to promote early identification of potentially suicidal and/or vulnerable clients through multidisciplinary identification, assessment and care plans for clients at-risk of self-harm and/or suicide. It defines suicide and self-harming behaviour as 'actions or threats of actions, which, if carried out, may lead to self-injury or death[79]'.

The program was governed overall by a SASH Policy Prevention Group with a Special Needs Care Team responsible for its applied day to day management. The General Manager had overall responsibility for the Suicide and Self-Harm (SASH) Prevention System and chaired the Suicide and Self-Harm Prevention Policy Group. This high level working group was multidisciplinary and included:

- The Senior Management Team (Operations Manager);
- Professional Support Services (Psychological Care);
- International Health and Medical Services (Primary Health Care);
- Special Needs Care Team (specifically appointed); and
- Invited key stakeholders (including DIMIA[80]) with responsibility for the review of SASH policy and processes to identify emerging trends and recommendations for improvements.

The Special Needs Care Team reviewed critical cases (meaning generally life threatening) at least daily and all other clients on SASH Prevention at least once a week and usually includes:

- the general Manager (or delegate): Convenor;

[77] Australian Parliament, *Chapter 3 – The Department's administration of its contract with Serco.* p.64. Available at: www.aph.gov.au. Accessed 20/05/2012.
[78] Detention Health Advisory Group, 2007, *Detention Health Advisory Group. Report against 2006-2007 Work Program*, p.7. Available at: http://www.immi.gov.au/. Accessed 18/05/2012.
[79] Global Solutions Ltd., *Generic Operational Procedure No.3.3 Suicide and Self-harm (SASH) Prevention CO-02-01_1*, p. 8. Unpublished.
[80] Department of Immigration and Multicultural Affairs, now Department of Immigration and Citizenship.

- Duty Operations Co-ordinator;
- DSO/s who work closely with the detainee;
- specified Health Services member (usually a Senior Nurse);
- psychologist/Counsellor;
- Specified Detention Services Officer;
- nominated representative from Programs/Education Section; and
- the DIMIA Manager will be invited to attend as well as others to provide input/advice from other areas.

Service delivery

Assessment of a detainee's risk of suicide and self-harm 'begins from the time of initial reception and continues for the entire period of detention[81]'. After an initial health assessment, relevant staff were briefed with regards to various aspects relating to a detainee's physical and mental health (amongst other issues).

In order to address concerns relating to a detainee, any person (all staff, irrespective of whether provider/stakeholder or visitor) could request for this to be formally noted in a SASH Placement Form by a Detention Services Provider Officer who then hands this to the Duty Operations Co-ordinator.

Where the form has come from persons other than IHMS or Professional Support Services, the Duty Operations Co-ordinator is responsible for immediately applying a watch observation plan, considering a change to the detainee's location/accommodation, requesting a Professional Support Services assessment and advising the General Manager. If an IHMS/PSS has submitted the form and deemed that the detainee should be placed on an alert placement (noting three occurrences of meaningful interactions per day), the Duty Operations Co-ordinator should commence the placement and advise the General Manager.

The Duty Operations Co-ordinator then instigates a Watch Observation Plan which is tailored to the level of assessed risk through a process of observation and intervention by the Special Needs Care team. There are six levels of Watch Observations:

- **Constant**: constant 1:1 observation, whilst located in an observation room with minimum of 1 assessment report every 30 minutes;

[81] Global Solutions Ltd., *Generic Operational Procedure No.3.3 Suicide and Self-harm (SASH) Prevention CO-02-01_1*, p. 12, Unpublished.

- **Intensive**: observed at a minimum of every four minutes, whilst located in an observation room, and 1 assessment report every hour (24 hours a day);
- **Random**: observed randomly, six times per hours, not more than fifteen minutes apart;
- **60 minute**: observed once every hour at a random time;
- **30 minutes**: observed twice every hour at random times;
- **Alert**: note three occurrences of meaningful interactions per day[82].

Where non-clinical staff place a detainee on a SASH observation, it must not be on an alert observation. It can only be either a constant, intensive, random, 60 or 30 minute watch.

A Watch log is established for each detainee, is assigned to a particular officer and filled out in accordance with the particular terms and conditions for that particular detainee and used during handover for shift changes. A duplicate Watch Log is maintained by the Control Officer and all observation forms are centrally collated, checked, signed and filed on the detainee's dossier.

As soon as is practical after a Watch Observation Plan is initiated, the Special Needs Care Team will be established and is responsible for designing a Care Plan to promote the wellness of the detainee. This plan will determine action plans and outcomes; strategies and approaches including changing the status of the Observation Plan and arranging for placement of the detainee under a buddy arrangement (sharing accommodation with another detainee who agrees to provide support and guidance).

Whilst a detainee is placed under SASH Prevention, staff will endeavour to establish and maintain a rapport with the individual, ensure the detainee is in a sterile living area (e.g. the room should be free of hanging points), the use of canvas clothing and bedding should be encouraged, engage in a low-key way with the detainee to give him/her reassurance that their safety and welfare is a personal responsibility of staff and ensure that the conditions of the log are scrupulously followed and every observation recorded.

Removal or step-down for clients on SASH Prevention is only possible where all members of the Special Needs Care Team agree with this action. In order to amend the level of assessed risk even if one member of the team disagrees, 'the level of observation continues but the [team] may direct expert assessment/investigation by specialists such as a psychologist or psychiatrist'. In order to remove a detainee from SASH Prevention, all members of the team must be unanimously satisfied that no more than minimal risk applies and the decision must be recorded by a health care professional on the Remove or Step-Down SASH form.

[82] ibid.

All staff who work with clients in facilities are required to be aware of the following indicators and signs which might suggest negativity or risk. During the detainee's initial first few days in detention, staff will be particularly aware of a number of factors including his/her:

- Medical history and psychiatric history; and
- Physical and emotional wellbeing and social supports.

During the detainee's subsequent time in detention, staff will also be aware of such as:

- changes in behaviour and personality e.g. self-mutilating behaviour, withdrawal, depression, attention seeking behaviour, changes in eating/sleeping patterns;
- triggers such as family stressors, family milestones, unfavourable detention decisions; and
- recent exposure to others attempting suicide or self-harm;

Annual 'booster' training sessions are provided for all staff and these include:

- A review of all SASH incidents for the previous year;
- Focus on improving identification, early intervention and prevention strategies;
- Staff training needs.

The SASH-PPG has responsibility for the systemic coordination and proactive management of the SASH policy and as part of its work is required to conduct reviews and report on a quarterly basis, identifying emerging trends and recommendations for improvements which are submitted by the General Manager to the National Operations Manager. The final quarter's review will include an evaluation of the previous year's operations.

Similarities and differences

The SASH Prevention procedures and PSP are similar in that they both recognise the importance of certain factors that are key for managing the risk of suicide and self-harm in the detention environment. For example, their respective procedural/policy guidelines emphasise the importance of cultural awareness and the presence of certain risk factors which may be more common for persons in the detention environment and both specify a particular level of supportive monitoring and engagement proportionate to the level of associated risk. However, these systems for the management of the risk of self-harm and suicide differ significantly in a number of ways, particularly in their respective governance and implementation procedures (Table 4).

Table 4: PSP and SASH Prevention

Similarities	Differences
Both the SASH Prevention General Operational Procedure and the PSP policy set out procedures for assessment of risk, referral, supportive monitoring and engagement, review and step-down/removal.	There is no SASH-Policy Prevention Group under the PSP, rather, the Health Services Manager is responsible for identifying triggers and contributing factors post-incident and providing the PSP team with written documentation and DIAC for input into quality improvement processes.
Both the SASH Prevention General Operational Procedure and the PSP policy specify the roles of stakeholders and the composition of multi-disciplinary team responsible for case review.	The Special Care Needs Team is multidisciplinary but is led by the General Manager whereas under the PSP it is led by the senior mental health clinician on the PSP team.
Both the SASH Prevention General Operational Procedure and the PSP specify the stressors and risk factors which staff should be trained in to identify risk of self-harm and suicide.	The SASH Prevention General Operational Procedure allows for non-clinical staff to make determinations about certain levels (all levels except Alert) of watch; there is no equivalent to supportive monitoring and engagement, which, under the PSP, provides detention service providers with a tool to support potentially at-risk clients until a clinician is available to make an assessment.
	The SASH Prevention General Operational Procedure requires unanimous consensus in decision-making with regard to re-assessment of risk and removal of client's from the program whereas the PSP indicates that the lead clinician on the PSP team, may make unilateral decisions on issues such as levels of risk and response, including referral for external assessment[83]'.
	The SASH Prevention General Operational Procedure highlights the importance of social supports in the detention environment, but does not have a specific focus on health promotion and prevention with a view to strengthening protective factors and enhancing resilience.
	The SASH Prevention General Operational Procedure does not specify that the post-incidence response must actively seek out and offer support to others who may be affected in the detention community as is indicated in the PSP.
	The SASH Prevention General Operational Procedure does not have a triggered re-assessment procedure (e.g. under PSP, re-assessment of risk is automatically conducted when a client receives a negative visa outcome).

[83] ibid., p.10.

	The SASH Prevention General Operational Procedure provides overall guidance on accommodation arrangements, restriction of movement and intervals for clinical review but not relative to the varying levels of assessed risk. For each level of risk the PSP provides guidance on monitoring and engagement, accommodation arrangements and clinical review.

Corrective Services NSW – at-risk Offenders

There are a number of limitations surrounding reviewing the implementation of Corrective Services' 'at risk' offender program to reduce suicide, self-harm and relapse of deliberate self-harm. Information that is publicly available includes the overall 'Principles for the Management of Possible Suicidal Behaviour in Corrections Health Service'[84], a study conducted by Eyland et.al in 1997 on 'Suicide Prevention in New South Wales Correctional Centres'[85], Annual Reports by Justice Health and Forensic Mental Health Network and information available on Corrective Services NSW website.

These sources of information provide an overview of systems, procedure and services/program available to inmates across the detention network, however, in-depth information with regard to recent data on implementation, training and outcomes does not appear to be publicly available, rather high level information is accessible with regard to policy developments and achievements as reported by Corrective Services in Annual Reports.

Introduction

In 1993, a committee was established to review suicide and self-harm in NSW correctional centres and delivered a number of key recommendations calling for an improvement in communications between Corrections Health Services and Department of Corrective Services and the establishment of units, similar to the Crisis Support Unit[86].

In 1995 a Taskforce into the Reporting of Deliberate Inmate Self-Harm was established to review the reporting of self-harm incidents. This Taskforce delivered a number of recommendations including the implementation of a three-stage classification system (to differentiate between a self-harm threat, self-harm act and suicide attempt), of procedures such as individual and corporate suicide plans and a rating scale for the severity of self-injury[87].

Health service delivery to inmates involves two separate organisations who are responsible for security and health care respectively[88]'. Since 1998, Corrective Services NSW has had an 'at risk' offenders program to reduce suicide, self-harm and relapse of deliberate self-harm among offenders in custody, upon release from custody and on community supervised orders. Justice Health and Forensic Mental Health network (a Statutory Health Corporation funded by NSW Ministry of Health) provides clinical care and support in the management of the program.

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[84] as documented by NSW health and implemented by Justice Health in the policy directive PD2005_121 (Jan 2005) on 'Suicidal Behaviour – Management of Patients with Possible Suicidal Behaviour'. NSW Government. Unpublished.
[85] Eyland et.al., 1997, *Suicide Prevention in New South Wales Correctional Centres*, Crisis, Vol.18.
[86] Ibid. p.166.
[87] Ibid. p.166.
[88] Justice Health & Forensic Mental Health Network, *Year in Review 2010/2011,* p.7. Available at: http://www.justicehealth.nsw.gov.au/. Accessed 23/05/2012. NSW Government.

Service delivery

Service delivery in the prevention of self-harm and suicide is conducted through a range of intervention programs including screening initiatives through to intensive therapeutic units. Screening is conducted by a nurse as part of the Reception Triage Process in order to identify whether an inmate is at-risk, to document risk and enhance case management by improving communication and management planning[89]' or at any other stage during the inmates' period of detention. It includes asking questions about suicidal ideation, coping skills while in custody, feelings of hopeless, having someone close to talk to about personal things, and the presence/absence of any suicide plans among other matters[90].

If a notification of risk is made (whether during screening or at any other point during the inmate's sentence), an alert is placed on the inmate's medical file and case file and a Risk Intervention Team notification form is completed. The Risk Intervention Team notification form incorporates three forms that attempt to differentiate between a threat of self-harm/suicide, a definite risk of self-harm/suicide and an actual self-harm/suicide.

A multidisciplinary management team, the Risk Intervention Team is then deployed and comprises a coordinator (who acts as the chair, is fully trained in the protocol and is always accessible at the centre), a high ranking custodial officer, a nurse and at least two other team members (who must have previously assessed the inmate) to discuss the management of the inmate's needs. The inmate's medical and psychology file are brought to the meeting so that comprehensive information sharing occurs to inform management decision-making. Management actions are itemised and recorded on the Risk Intervention Team notification forms and include options such as the use of "two out" (two in a cell), use of a safe cell and formal reassessment date (typically the next day). The Risk Intervention Teams' work and processes are integrated into the broader case management of the individual inmate to maintain an integrated approach and ensure that the inmate's case file is up to date.

A number of mental health services and treatment options/programs are available for inmates at-risk of self-harm or suicide across the corrective services network including:

- Mental Health Screening Units;
- Ambulatory Mental Health Services;
- specialist mental health consultation (visiting psychiatrists, mental health nurses, 24 hour on call psychiatrist and registrar);
- Risk Assessment Intervention Teams;

[89] Eyland et.al., 1997, *Suicide Prevention in New South Wales Correctional Centres,* Crisis, Vol.18, no.4.
[90] Ibid, p.167.

- Psychiatric Emergency Telehealth Services[91];
- prisoner support schemes (peer support programs);
- Acute crisis management units;
- safe cells (various levels of observation may be required but periodic face-to face communication at a minimum, with no inmate kept in a cell for more than 48 hours);
- inpatient mental health services including the Long Bay and Forensic Hospitals, as well as organising inpatient and specialist care for people in custody in community-based hospitals.

In 2010/11, 2,316 inmates were identified as at-risk and referred for assessment prior to an actual self-harm incident[92].

In terms of training in self-harm and suicide prevention, the following is provided:

- general staff training which aims to support the state-wide suicide prevention strategy that has been developed;
- suicide awareness training for all custodial staff run by Department of Corrective Services' training academy;
- suicide awareness and risk-assessment training run by the Corrections Health Service for all multidisciplinary staff;
- specialised training for custodial staff in intensive program units;
- ongoing formal and informal group work supervision by specialist staff in intensive program units[93].

In 2010/11, 355 frontline staff received training in Mental Health First Aid, 416 in Suicide Awareness and Immediate Intervention, and 162 in Risk Intervention Teams Protocol Training[94].

Similarities and differences

There are a number of similarities and differences in the management of the risk of suicide and self-harm in detention under the PSP policy compared with the program in NSW correctional

[91] Justice Health & Forensic Mental Health Network, *Year in Review 2010/2011,* p.28. Available at: http://www.justicehealth.nsw.gov.au/. Accessed 23/05/2012. NSW Government.
[92] NSW Department of Attorney General and Justice, *Corrective Services NSW*, p.115 Available at: http://www.lawlink.nsw.gov.au/ . Accessed: 14/06/2012.
[93] Eyland et.al., 1997, *Suicide Prevention in New South Wales Correctional Centres*, Crisis, Vol.18, no.4.,p.168
[94] NSW Department of Attorney General and Justice, *Corrective Services NSW*, p.115. Available at: http://www.lawlink.nsw.gov.au/. Accessed: 14/06/2012.

settings. Both programs make determinations about level of risk and have multidisciplinary teams and processes for the management of that risk. However, correctional facilities are much more strongly linked with the community outside the correctional facilities given their integration into the broader health network, policies and programs and have a stronger focus on the integration of the management of 'at-risk' offenders into broader case management of the individual (Table 5).

Table 5: PSP and At-Risk offender management NSW

Similarities	Differences
The model of health care is similar in that service delivery is organised through a number of agencies where one agency is primarily responsible for the delivery of health care.	Justice Health and Forensic Mental Health Network is integrated with the state-based health service and therefore has stronger linkages with services and programs outside the correctional environment.
Both programs involve screening and assessment during induction into the setting and can be triggered at any time.	Fewer mental health service options are available within the immigration detention network (e.g. inpatient mental health services) compared with the NSW corrective services environment.
	Integration of the Risk Intervention Teams' work and processes is more strongly integrated into broader case management of the individual than is the case under the PSP.

5.3.3 Department of Corrective Services WA – Prisoners at-risk of self-harm or Requiring Additional Support and Monitoring

Similarly to examining implementation of self-harm and suicide prevention strategies in correctional settings in NSW, there are limitations around the information that is publicly available regarding the procedures in place for the prevention and management or at-risk prisoners. Rather, a high level policy directive 'Policy Directive 32 Prisoners at-risk of self-harm or Requiring Additional Support and Monitoring' and Department of Corrective Services Annual Report 2010/2011 provide an overview as to how the program is structured and rationale but no further detail as to procedural guidelines surrounding implementation and more in-depth information about the training delivered and outcomes.

Introduction

In June 2000, the Department of Justice set up a Suicide Prevention Taskforce in response to the alarming[95] rates of suicide throughout Western Australian Prisons despite a number of initiatives

[95] Ibid. p.17

including the introduction of At-Risk Management System (ARMS), the amalgamation of the Special Needs Team (suicide prevention team of psychologists and social workers) with Prison Health Services to create a Forensic Case Management team. The Taskforce developed a number of recommendations including:

- Giving priority to the provision of comprehensive mental health services:
    - A multi-disciplinary model for screening and assessment of mental illness;
    - Adequate mental health treatment and management resources and systems within prisons;
    - Sufficient provision of external hospital accommodation for the treatment and management of acute mental illness; and
    - Continuity of mental health care from specialist management and treatment facilities, back into the mainstream prison environment, and ultimately into the community.
- Providing suicide awareness training to prison officers and other prison staff[96].

Service delivery

Policy Directive 32 Prisoners at-risk of self-harm or Requiring Additional Support and Monitoring governs indicates that the suicide prevention model currently in place in Western Australian prisons is based on the public health model which requires multiple approaches across three levels:

- **primary prevention**: strategies which aim to create a physical and social environment in the prison that limits stress on prisoners e.g. through comprehensive induction/orientation, anti-bullying policies;
- **secondary prevention**: strategies that aim to support prisoners at statistically higher risk of suicide or self-harm; and
- **tertiary prevention:** strategies which are aimed directly at individuals who are identified as at-risk of self-harm or suicide. Increased monitoring, the provision of psychological intervention, and/or placement in a safer environment if necessary[97].

The Prison Counselling Service, in addition to providing individual counselling sessions for prisoners 'who are having trouble coping in prison,...assesses prisoners to see if they have any

[96] Ibid. p.86-87
[97]Department of Corrective Services, 2004, *Policy Directive 32, Prisoners at-risk of self-harm or Requiring Additional Support and Monitoring, p.2-3.* Available at: http://www.correctiveservices.wa.gov.au/. Accessed 23/05/2012. Government of Western Australia.

self-harm, suicide or other risk factors[98]'. It comprises psychologists and social workers. There is also a team of Aboriginal staff who visit prisons and detention centres to provide support and culturally-appropriate advice to prisoners under the Aboriginal Visitors Scheme.

Two systems are implemented as part of suicide prevention activities: the ARMS and the Support and Monitoring System (SAMS). ARMS requires a whole of prison approach and is a multi-disciplinary case management system for the prevention and management of risk of acute self-harm and suicidal crisis; SAMS is a collaborative case management system for prisoners who are not at-risk to self, but have been identified as requiring multidisciplinary intervention and additional support and monitoring[99].

All prisons and detention centres provide a mental health service made up of a specialised team of mental health nurses, addiction specialists and consultant forensic psychiatrists. The mental health team offers the following services:

- identifying prisoners with a mental illness, liaising with agencies who have cared for those prisoners in the past and continuing appropriate treatment before discharging the prisoner into community care when they are released;
- assessing prisoners for the Courts and the Prisoners Review Board to help them make decisions about appropriate sentences or parole conditions;
- providing mental health education to prisoners;
- liaising with other health professionals, including working closely with the Frankland Unit at Graylands Hospital.

Crisis care units are provided at Bandyup Women's Prison, Casuarina and Hakea prisons and are staffed 7-days-a-week by mental health specialists.

The ARMS, SAMS and mental health services which work together to reduce the risk of self-harm and suicide amongst prisoners and are underpinned and supported by a variety of other measures including:

- initiatives for reducing prison stressors (e.g. improving induction and orientation processes, anti-bullying policy, streamlining prisoner grievance processes);

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[98] Department of Corrective Services, *Counselling and support.* Available at: http://www.correctiveservices.wa.gov.au/rehabilitation-services/counselling-support.aspx#Prison-counselling-service. Accessed: 23/05/2012. Government of Western Australia.
[99] Department of Corrective Services, 2004, *Policy Directive 32, Prisoners at-risk of self-harm or Requiring Additional Support and Monitoring,* p.1. Available at: http://www.correctiveservices.wa.gov.au/_files/prisons/adult-custodial-rules/policy-directives/pd-32.pdf. Accessed 23/05/2012. Government of Western Australia.

- the use of prisoner peer support teams;
- the 'Integrated Prison Regime' (training and other initiatives aimed at improving the overall functioning of prisons with regard to such matters as prisoner safety, prisoner support, and the development of mutual respect between officers and prisoners[100]); and
- the principle of shared responsibility.

In 2010/11, 11,702 referrals were made to the Prison Counselling Service, a total of 2,639 prisoners were referred to ARMS and 335 prisoners were referred to SAMS.

Suicide awareness training courses and a two-day Gatekeeper suicide awareness workshop are delivered to Corrective Services Department staff and prisoners in order to increase participants' ability to identify and refer people considered to be at-risk. In 2010/11, 114 prisoners and 442 staff completed the Gatekeeper workshop[101].

Similarities and differences

Similarly to the model implemented by corrective services in New South Wales, mental health services in the corrections environment in Western Australia is strongly integrated with the state health service: 'Prisoners with a mental illness are managed as they would be in the public health system, with the Department using a process of assessment, diagnosis and ongoing treatment'. There are a number of similarities and differences between the PSP and self-harm and suicide prevention in the corrections environment in Western Australia (Table 6).

Table 6: PSP and Prisoners at-risk of self-harm or Requiring Additional Monitoring and Support

Similarities	Differences
Both approaches involve multidisciplinary case management teams and focus on the early identification of those at-risk of suicide or self-harm, health promotion and preventative strategies.	Under the Prisoners at-risk of self-harm or Requiring Additional Monitoring and Support policy, there is a an emphasis on shared responsibility and the use of peer support teams.
Both approaches include both preventative strategies and a multidisciplinary, collaborative case management system for those who require additional support and monitoring once a risk has been identified.	Under the Prisoners at-risk of self-harm or Requiring Additional Monitoring and Support policy, there is an additional tier (secondary prevention) aimed at supporting individuals at statistically higher risk of suicide or self-harm.

[100] Suicide Prevention Taskforce, 2002, *Suicide in Prison*, p.21. Available at: http://www.correctiveservices.wa.gov.au/. Accessed 23/05/2012. Government of Western Australia.
[101] Department of Corrective Services, 2011, *Annual Report 2010/2011*, p.58. Available at: http://www.correctiveservices.wa.gov.au/. Accessed 23/05/2012.

	The PSP policy is not underpinned by a concept of shared responsibility that includes an emphasis on client responsibility and client peer support models.
	PSP training is directed at staff but not at clients.
	Self-harm and suicide prevention strategies in corrections in Western Australia are explicitly linked with other initiatives in the prison system surrounding reducing prison stressors, peer support teams and training aimed at improving the overall functioning of prisons.

HM Prison Service United Kingdom: Assessment, Care in Custody and Teamwork (ACCT) Approach

The following section details the Assessment, Case in Custody and Teamwork (ACCT) approach in place in HM Prison Service in the United Kingdom. The sections below provide a brief background to the introduction of this approach followed by a description of the procedures underpinning its implementation as outlined in the ACCT Pocket Guide for Staff. There appears to be a lack of publicly available information regarding the implementation, training and outcomes surrounding the delivery of this approach.

Introduction

In response to the rising number of suicide and high rates of self-harm, HM Prison Service issued a Prison Service Order (PSO) 2700 (suicide and self-harm prevention) in 2003, following the Internal Review of the Prevention of Suicide and Self-Harm in the Prison Service to align the management of the risk of suicide and self-harm in prisons with research and best practice. This PSO aims to provide prison staff with instructions to assist in the identification of prisoners at-risk of self-harm and suicide, care and support and to shift the focus from awareness to include prevention[102] through a multi-disciplinary, multi-agency, whole-prison approach[103].

[102] Minister of State, Home Office, *Prison Service: Safer Custody*, Available online at: http://www.publications.parliament.uk/. Accessed 24/05/2012.
[103] Ministry of Justice, 2007, *60. Suicide Prevention and Self-Harm Management,* Available at: http://www.justice.gov.uk/ . Accessed 24/05/2012.

Service delivery

The approach guiding the PSO 2700 is the Assessment, Care in Custody and Teamwork (ACCT) - Caring for People at-risk in Prison. The PSO 2700 is a national policy providing instructions as to how this approach should be implemented locally by specifying roles, responsibilities, case management, referral pathways, administrative instructions and the collection of data.

The AACT Pocket Guide for Staff firstly details distress signals that can be 'detected by observing listening and asking' and describes behaviours, thoughts, feelings, physical changes and situation/triggers staff may observe to assist them in recognising risk[104]. The following instructions are provided for staff including a flowchart to provide an overview of the process (see Figure 17 below).

- **Make an initial response**: this provides guidance as to how staff should assess how the individual is feeling by talking to them and the kind of questions they might ask (etc.) if they believe the there is a risk of suicide and self-harm that they should alert other staff and open an ACCT Plan;

- **How to open an ACCT plan**: Any staff member can open an ACCT plan by completing the plan (including the Concern and Keep Safe form) and must follow local procedures to obtain a log number, inform the ACCT administrative support officer, and pass the ACCT plan to the prisoner's/trainee's Unit Manager or the Night Orderly Officer;

- **Immediate Action Plan:** The Unit Manager (after consultation with appropriate staff) will decide how to keep the prisoner/trainee safe (this may entail a referral to health care) until a more detailed assessment can be carried out;

- **Assessment:** The Unit Manager will notify the Assessor Team and arrange for an Assessor to interview the person at-risk within 24 hours. The interview will identify the risk and contribute to the Case Review;

- **First Case Review:** A Case Review is held immediately after the Assessment Interview and is chaired by the Unit Manager and attended by the prisoner/trainee, Assessor and other appropriate staff; the level of risk will be agreed and a care and management plan drawn up. The Case Review Team will provide information regarding triggers and the frequency of conversations and observation and determine when to hold the next Case Review. The team will also make a referral to mental healthcare for a mental health assessment if they determine that the person has mental health problems and/or high risk and/or actual self-harm.

[104] HM Prison Service, *The ACCT Approach – Caring for People at-risk in Prison – Pocket Guide for Staff*. Unpublished.

- **Closing an ACCT Plan:** The person at-risk should be prepared for closure over time by being encouraged to build up their own support networks and coping strategies and reducing levels of support gradually. The plan is to be closed at a Case Review with approval from the Case Review Team ensuring that problems that caused the ACCT Plan to be implemented have been resolved or reduced in intensity and arranging for a follow-up interview[105].

Ongoing case management involves:

- All staff following the ACCT Plan including: reading the care and management plan and the trigger box (to familiarise themselves with the triggers for that particular case) and record events, conversations with the individual or observations in the on-going record;

- Conducting Case Reviews organised and chaired by case managers involving the key people who know the person at-risk or are involved in his/her case, the person at-risk to review key issues such as problems that have arisen, how these can be resolved, whether the person at-risk has been put in contact with social supports etc.

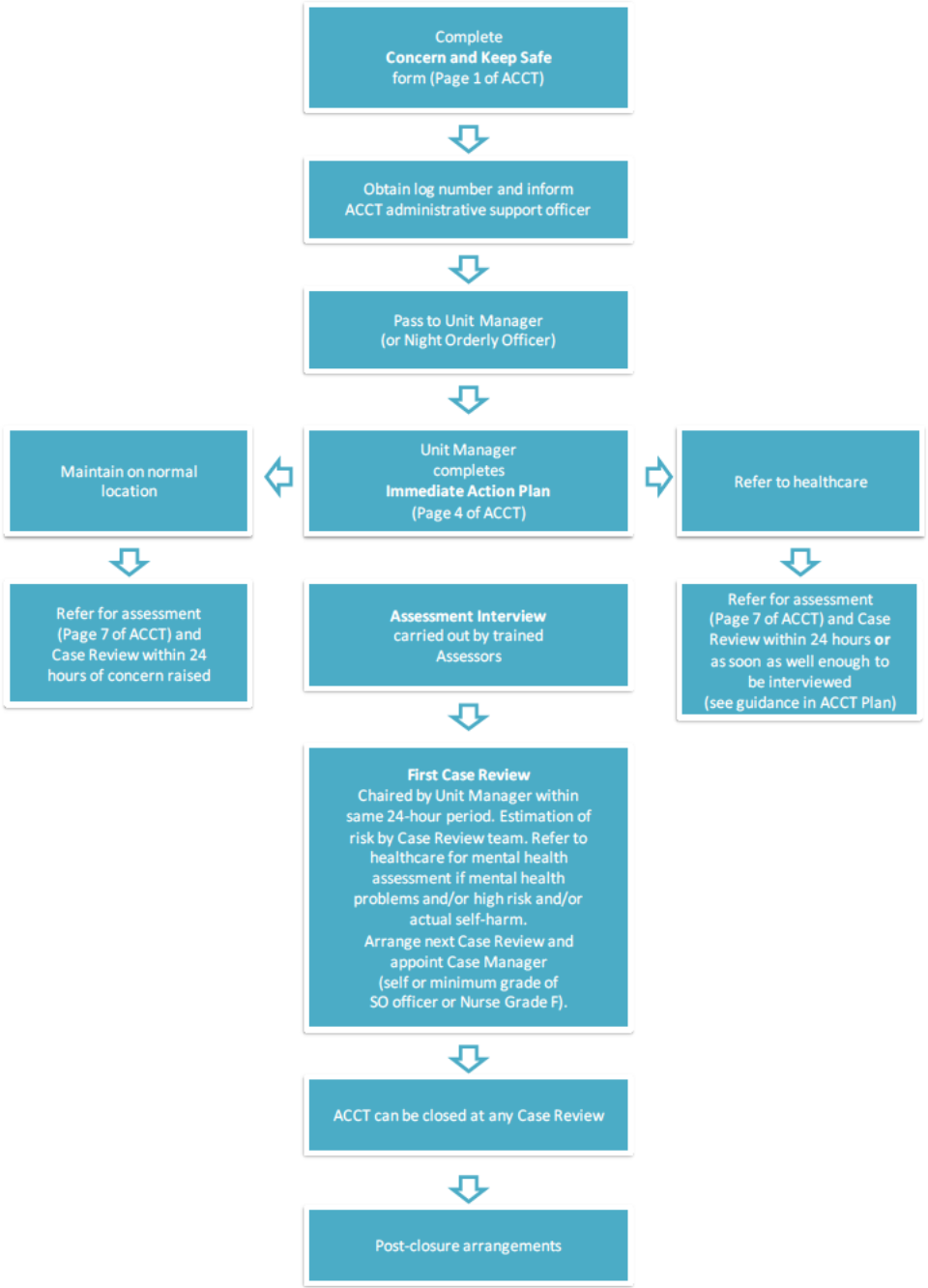
- Ensuring that information relating to the case is appropriately documented in the Local Inmate Data System as well as through accurate records management (including filling out appropriate incident forms).

The ACCT Plan also documents the responsibilities of Unit managers and Night Orderly Officers, Case Managers and healthcare staff, how those at-risk should be handled upon arrival and departure from/to another establishment, special issues for children-at-risk and strategies for staff in supporting the person at-risk and how to provide a safe environment (e.g. through a shared cell arrangement or safer cell, or secluded accommodation as a last resort), and how staff can be supported.

ACCT Foundation Training is delivered, as part of the induction programme, to all new staff who have direct prisoner contact[106].

[105] ibid.
[106] Ministry of Justice, 2007, *60. Suicide Prevention and Self-Harm Management,* p.2. Available at: http://www.justice.gov.uk/. Accessed 24/05/2012.

Figure 17: Assessment, Care in Custody and Teamwork (ACCT) Flow Chart



Similarities and differences

The PSP and ACCT approaches are similar in that they both identify the importance of preventative and whole of system approaches, however, they differ in terms of assessment and referral pathways, the level of clinical leadership built into the approach (there is a greater role in PSP) and the extent to which the detainee/client is involved in the management of their case (Table 7).

Table 7: PSP and the ACCT Approach

Similarities	Differences
Both the ACCT and PSP have arrangements in place to keep a person at-risk of self-harm or suicide safe until the case can be reviewed.	The Case Review Team differs from the PSP Team arrangements in that, even though both are multidisciplinary the Case Review Team is led by a non-clinical staff member.
	The Case Review Team, does not necessarily include a clinical staff member with a specialisation in mental health.
	The person at-risk of self-harm or suicide is actively involved in the management of their case through the Case Review Team whereas this is not specified under the PSP team arrangements.
	Both the ACCT and PSP have procedures in place for actively supporting the person at-risk in stepping down from the plan/program, however, this is lead by the clinician leading the PSP team whereas the ACCT approach provides strategies for non-clinical staff to manage this as well as an instruction to arrange a follow-up interview.
	Referral to health care is not automatic under the ACCT, the appropriate course of action is determined by the Unit Manager; under the PSP referral is automatic when a mental health clinician is available.

C

APPENDIX C: QUESTIONNAIRE

Department of Immigration and Citizenship

Job #: 11-064567-01

Evaluation of the Psychological Support Program
Online Staff Survey

(DRAFT Version: 29th April 2012)

BACKGROUND TO PROJECT

This survey provides an opportunity for staff working with clients in immigration detention centres, and their managers, to comment on their experience supporting clients who may be at-risk of self-harm or suicide.

---------- **[NEW SCREEN]** ----------

INTRODUCTION

Thank you for agreeing to participate in this survey.

The Department of Immigration and Citizenship has commissioned the Ipsos Social Research Institute as an independent research organisation to conduct a survey to better understand your experiences of working with clients who are at-risk of self-harm.

This survey is intended to be completed by staff who have direct contact with clients or their managers.

This survey will take approximately 10 minutes to complete.

Privacy statement:

The results of this study will be reported in aggregate to the Department of Immigration and Citizenship and your responses will be anonymous. You are not required to provide your name in this survey and no other data that could identify a person will be reported or released by Ipsos.

If you have difficulties with the questions or with accessing the survey online please call Cheryl Reed on 03 9946 0836 or email cheryl.reed@ipsos.com.

[Note: The Australian Market and Social Research Society's Surveyline on 1300 364 830 is available for you to call if you would like to check if Ipsos is recognised by the society as a bona fide research company]

[PROGRAMMING NOTE: PLEASE DO NOT INCLUDE SECTION HEADINGS ON SCREEN]

---------- **[NEW SCREEN]** ----------

SECTION A: AWARENESS

Q1. Do you know that there is a program in place for the prevention of self-harm in immigration detention? **[SINGLE RESPONSE]**

Yes **[GO TO Q2]**----------01
No **[GO TO Q3]**----------02
Not sure **[GO TO Q3]** ----------99

---------- **[NEW SCREEN]** ----------

[IF Q1=01, ASK Q2]

Q2. Can you please tell us what this program is called? **[OPEN ENDED]**

---------- **[NEW SCREEN]** ----------

[ASK ALL]

Q3. This survey is about the **Psychological Support Program (PSP)** for the prevention of self-harm and suicide in immigration detention. The program 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; and
-to reduce the level of uncertainty and stress for staff dealing with persons in immigration detention who exhibit self-harming and suicidal behaviour.

Before today, had you heard of this? **[SINGLE RESPONSE]**

Yes **[GO TO Q4]**----------01
No **[GO TO Q6]**----------02

---------- **[NEW SCREEN]** ----------

[IF Q3=01, ASK Q4]

Q4. How did you hear about the PSP? **[MULTIPLE RESPONSE. RANDOMISE ROWS]**

Induction training when you started work----------01
Formal training after you had been working for a while----------02
Policy/procedure manuals----------03
Co-workers----------04
Line manager----------05
Other **[PLEASE SPECIFY]**----------99

---------- **[NEW SCREEN]** ----------

Q5. How would you rate your knowledge of the PSP? **[SINGLE RESPONSE]**

Poor----------01
Fair----------02
Good----------03
Very Good----------04
Excellent----------05
Don't know----------99

---------- **[NEW SCREEN]** ----------

[ASK ALL]

Q6. And how would you like to be kept up to date about the Psychological Support Program in the future? **[MULTIPLE RESPONSE]**

Reminder posters----------01
Checklists----------02
On the job training----------03
Policy/procedure manuals----------04
Co-workers----------05
Line manager----------06
Other **[PLEASE SPECIFY]**----------07

---------- [NEW SCREEN] ----------

Q7. Do you do either of the following in your current role? **[SINGLE RESPONSE]**

		Yes	No
A	Work directly with clients	1	2
B	Manage staff who work directly with clients	1	2

ASK Q8 IF Q3=1 ELSE GO TO Q10

Q8. Have you ever worked with clients who were being supported through the PSP?

Yes ----------01
No ----------02
Don't know ----------99

---------- [NEW SCREEN] ----------

[IF Q7=01, ASK Q9. IF Q7=02 OR 99, SKIP TO Q10]

Q9. Have you been supporting clients on PSP in your current role? **[MULTIPLE RESPONSE]**

Yes, in my **current** role ----------01
Yes, in my **former** role ----------02
Never **[EXCLUSIVE]** ----------03
Don't know **[EXCLUSIVE]** ----------99

SECTION B: PSP TRAINING

[ASK ALL Q10]

Q10. Have you received any formal training in any of the following areas? **[MULTIPLE RESPONSE]**

General issues in mental health ----------01
Psychological Support Program (PSP) ----------02
None of these ----------03
Don't know ----------99

---------- [NEW SCREEN] ----------

[IF Q10=2, ASK Q11. ELSE GO TO PRE Q12]

Q11. Thinking about training on the PSP could you please rate the following aspects: **[SINGLE RESPONSE PER ROW, RANDOMIZE A TO F]**

		Poor	Fair	Good	Very good	Excellent	Don't Know
a	Availability of PSP training to you	1	2	3	4	5	99
b	The usefulness of the PSP training to your day to day job	1	2	3	4	5	99
c	The level of PSP training (ie not too hard or easy)	1	2	3	4	5	99
d	Knowledge of the presenter	1	2	3	4	5	99
e	The quality of the PSP training materials	1	2	3	4	5	99
f	Duration of PSP training	1	2	3	4	5	99
g	Overall satisfaction with training	1	2	3	4	5	99

---------- **[NEW SCREEN]** ----------

SECTION C: PARTNERSHIPS

[PRE Q12. ASK IF Q3=1 ELSE GO TO Q13]

Q12. Thinking about how you see the PSP being implemented in your current workplace overall, please rate the following aspects: **[SINGLE RESPONSE PER ROW, RANDOMIZE A to D]**

		Poor	Fair	Good	Very good	Excellent	Don't Know
a	How well staff from the DIAC, Serco and IHMS work together	1	2	3	4	5	99
b	Communication within **your own organisation** about clients in relation to PSP	1	2	3	4	5	99
c	Communication with staff from **other service providers** about clients in relation to PSP	1	2	3	4	5	99
d	The quality of client information in relation to PSP	1	2	3	4	5	99

e	Overall access to the information you need about clients in relation to PSP	1	2	3	4	5	99

---------- [NEW SCREEN] ----------

SECTION D: IMPLEMENTATION OF PSP

Q13. Thinking about the prevention of self-harm, please rate how competent you feel in the following areas: **[SINGLE RESPONSE PER ROW, RANDOMIZE ROWS a to e]**

		Poor	Fair	Good	Very good	Excellent	Don't Know/ Not relevant to my role
a	Engaging with clients in a way that is meaningful	1	2	3	4	5	99
b	Supporting clients to create/maintain social and emotional supports	1	2	3	4	5	99
c	Understanding of language and cultural differences	1	2	3	4	5	99
d	Communicating and engaging with clients	1	2	3	4	5	99
e	Managing the environment to limit opportunities for self-harm	1	2	3	4	5	99
f	Overall, how confident do you feel to work with clients are at-risk of self-harm or suicide?	1	2	3	4	5	99

---------- [NEW SCREEN] ----------

Q14. Thinking about identifying whether a client is at-risk of self-harm, please rate your confidence in the following: **[SINGLE RESPONSE PER ROW, RANDOMIZE ROWS]**

		Poor	Fair	Good	Very good	Excellent	Don't Know
a	Communicating with other staff to gather information about a clients' risk	1	2	3	4	5	99
b	Recognising at-risk behaviours	1	2	3	4	5	99
c	Preventing at-risk behaviour	1	2	3	4	5	99
d	Explaining your concerns to others	1	2	3	4	5	99
e	Having your concerns about a clients' risk being taken seriously by others	1	2	3	4	5	99

---------- **[NEW SCREEN]** ----------

[ASK Q15 IF Q3=1 ELSE GO TO Q18]

Q15. From your experience, please rate how well PSP procedures work in the following circumstances: **[SINGLE RESPONSE PER ROW, RANDOMIZE ROWS]**

		Poor	Fair	Good	Very good	Excellent	Don't Know
a	PSP procedures for supporting a person who is identified as at-risk when the mental health staff **are not on duty**	1	2	3	4	5	99
b	PSP procedures for supporting a person who is identified as at-risk when the mental health staff **are on duty**	1	2	3	4	5	99

---------- **[NEW SCREEN]** ----------

SECTION E: SUMMARY

Q16. Overall, how well do you think the PSP is working to support clients at-risk of self-harm? **[SINGLE RESPONSE]**

Poor----------01
Fair----------02
Good----------03
Very Good----------04

Excellent----------05
Don't know ----------99

---------- [NEW SCREEN] ----------

Q17. Are there any ways in which you believe the implementation of the PSP could be improved? **[OPEN RESPONSE]**

SECTION F: DEMOGRAPHICS

Q18. Please record your gender **[SINGLE RESPONSE]**

Male---------- 01
Female---------- 02

Q19. Into which of the following age brackets do you belong? **[SINGLE RESPONSE]**

18-29 years ----------01
30-39 years ----------02
40-49 years ----------03
50-59 years ----------04
60+ years ----------05
I'd prefer not to say ----------99

---------- **[NEW SCREEN]** ----------

Q20. Do you currently work at an immigration detention facility? **[SINGLE RESPONSE]**

Yes **[GO TO Q21]** ----------01
No **[GO TO Q22]** ----------02

---------- **[NEW SCREEN]** ----------

[IF Q20=1, ASK Q21]

Q21. At which immigration detention facility do you currently work? **[MULTIPLE RESPONSE]**

Adelaide ITA ----------01
Berrimah House ----------02
Brisbane ITA----------03
Christmas Island IDC ----------04

Construction Camp APOD ----------05
Curtin IDC ----------06
Darwin Airport Lodge APOD ----------07
Inverbrackie APOD ----------08
Leonora APOD ----------09
Maribyrnong IDC ----------10
Melbourne ITA ----------11
Northern IDC ----------12
Perth IDC ----------13
Perth IRH ----------14
Phosphate Hill APOD ----------15
Port Augusta IRH ----------16
Scherger IDC ----------17
Sydney IRH ----------18
Villawood IDC ----------19
Wickham IDC ----------20
Yongah Hill IDC ----------21
Other ----------98

---------- **[NEW SCREEN]** ----------

[ASK ALL Q22]

Q22. Aside from your current position, have you ever worked at an immigration detention facility? **[SINGLE RESPONSE]**

Yes **[GO TO Q23]** ----------01
No **[GO TO Q24]** ----------02

---------- **[NEW SCREEN]** ----------

[IF Q22=1, ASK Q23, ELSE GO TO Q24]

Q23. And at which immigration detention facility/facilities have you worked in the past? **[MULTIPLE RESPONSE]**

Adelaide ITA ----------01
Berrimah House ----------02
Brisbane ITA ----------03
Christmas Island IDC ----------04
Construction Camp APOD ----------05
Curtin IDC ----------06
Darwin Airport Lodge APOD ----------07

Inverbrackie APOD ----------08
Leonora APOD ----------09
Maribyrnong IDC ----------10
Melbourne ITA ----------11
Northern IDC ----------12
Perth IDC ----------13
Perth IRH ----------14
Phosphate Hill APOD ----------15
Port Augusta IRH ----------16
Scherger IDC ----------17
Sydney IRH ----------18
Villawood IDC ----------19
Wickham IDC ----------20
Yongah Hill IDC ----------21
Other ----------98
None **[EXCLUSIVE]** ----------97

---------- **[NEW SCREEN]** ----------

Q24. Which of the following best describes the area in which you work? **[MULTIPLE RESPONSE. RANDOMISE ROWS]**

Welfare ----------01
Case management ----------02
Mental health ----------03
General health ----------04
Learning and development ----------05
Activities ----------06
Security ----------07
Client services ----------08
Care management ----------09
Detention operations ----------10
Language interpretation ----------11
Cultural support ----------12
General management ----------13
Other **[PLEASE SPECIFY]** ----------98
Don't know ----------99

---------- **[NEW SCREEN]** ----------

Q25. And how long have you been working in your current role? **[SINGLE RESPONSE]**

0-1 month ----------01
2-3 months ----------02
4-5 months ----------03
6-12 months ----------04
1-2 years ----------05
2-3 years ----------06
4 + years ----------07
Don't know ----------99

---------- **[NEW SCREEN]** ----------

Q26. And how long have you been working in immigration detention overall? **[SINGLE RESPONSE]**

0-1 month ----------01
2-3 months ----------02
4-5 months ----------03
6-12 months ----------04
1-2 years ----------05
2-3 years ----------06
4- 10 years ----------07
10 + years ----------08
Don't know ----------99

---------- **[NEW SCREEN]** ----------

[END SCREEN]

Thank you for participating in this important survey.

D

This section provides a summary of the interview schedule for the IDF site visits

APPENDIX D: IDF SITE VISIT SCHEDULE

Table 8: IDC Site Visit Schedule

Darwin site visit: 20th-22nd of March 2012					
Date	**Site**		**Time**	**Organisation**	**Format/setting**
20-Mar	DAL 3	PM	2.00	IHMS	One to one interview
			2.30	IHMS	One to one interview
			3.00	IHMS	One to one interview
			4.45	DIAC	Group discussion, 5 attendees
21-Mar	NIDC	AM	8.30	IHMS	One to one interview
			11-11.45	Serco	Group discussion, 5 attendees
		PM	2.00	DIAC	Paired depth interview
			3.00	DIAC	Triad
22-Mar	WP	AM	8.30	IHMS	One to one interview
			9.00	IHMS	One to one interview
			9.30	IHMS	One to one interview
			10.30	Serco	Tour of site and spoke with 6 staff
			11.30	DIAC	Group discussion, 8 attendees
	DAL 1/2	PM	2.00	IHMS	One to one interview
			2.30	IHMS	Paired depth interview
			3.30	LWB	Paired depth interview
			4.00	Serco	One to one interview
Total					**42**

Villawood IDC site visit: 28th-29th March 2012				
Date		**Time**	**Organisation**	**Format/setting**
28-Mar	PM	12:30	DIAC	One to one interview
		1	DIAC	One to one interview
		1:30	DIAC	Group discussion, 7 attendees
		2	Serco	One to one interview
		2:30	Serco	One to one interview
		3-4	IHMS	Paired depth interview
		4	Serco	One to one interview
		4:30	Serco	One to one interview
29-Mar	AM	9.00 - 10.30	DIAC	Triad
		10:30 - 11.30	DIAC	Triad
		11:30	Serco	Tour of residential unit/one to one interview
		12	Serco	Tour of facility/one to one interview
	PM	12:30	Serco	One to one interview
		1 -2	Serco	Triad
		2	Serco	One to one interview
		2:30	Serco	One to one interview
		3	DIAC	Triad
		3:30 - 4.30	IHMS	Group discussion, 5 attendees
Total				**37**

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