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Report:

Clinical Review of Mental Health Services in Australian Immigration Detention

Interim Report prepared: 25 June 2020

Clinical Review Dates	
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Report preparation	Department's Clinical Advice and Support Provider, Blugibbon.

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1. Glossary of Abbreviations

Term	Definition
ABF	Australian Border Force
Apollo	Electronic Medical Records system managed by IHMS
CAT	Clinical Advisory Team
CMO	Chief Medical Officer
DOI	Department of Immigration
DSM	Detention Service Manual
ERT	Emergency Response Team officer (SERCO officer)
FDSP	Facilities and Detainee Service Provider
GP	General Practitioner
HSP	Health Services Provider
IDF	Immigration Detention Facility
IDN	Immigration Detention Network
IHMS	International Health and Medical Services
MOC	Medical Officer of the Commonwealth
Officer	A staff member employed by the department who has met the necessary training requirements to be classed as an officer under the <i>Migration Act 1958</i>
SOP	Standard Operating Procedures
the Department	the Department of Home Affairs
TORs	Terms of Reference
IMP	Individual Management Plan
BMP	Behaviour Management Plan
SME	Supportive Monitoring and Engagement
PSP	Psychological Support Program
EMR	Electronic Medical Record
DHSP	Detention Health Service Provider
SERCO	
ACCT	Assessment, Care in Custody and Teamwork
Charter	Mental Health Procedural Instruction (DM-6320, ADD2019/984931)

1. Executive Summary

The review found that:

- Mental Health Services currently are being provided beyond the charter of contracted services, via an assertive whole-of-population case management model with specialist input.
- There is scope for improvement in services, with specific recommendations in the areas of: Documentation, Consent, Model of Care, Management Plans, Challenging Behaviour, Screening and Assessment, and Community Interventions
- There is potential for considerable improvement in the quality of life of detainees, by organisational framework interventions, with likely minimal additional cost.

2. Scope of the review

This report was commissioned in order to address the following questions:

- 1.) Are mental health services being provided according to Charter?
- 2.) Are the management plans implemented for each patient according to appropriate standards?
- 3.) Is there a need to adjust the Charter in order to improve mental health services to detained individuals?

The review was limited to persons located in onshore immigration detention facilities (IDFs).

Consultations occurred with:

- 1.) SERCO
- 2.) IHMS - Medical Director, Director of Operations, Quality Manager, IHMS frontline clinicians including Psychiatrist, Social Worker, Nurses
- 3.) ABF - Detention Officers
- 4.) Professor Don Grubin (Internationally recognised expert on forensic behaviour management)

Engagements outstanding: Detainees; Commonwealth Ombudsman

3. Background

3.1. Context

Ethical context

The delivery of care in detention settings is a controversial issue. A systematic review (Werthern 2018) identified that immigration detention had adverse effects on mental health. The Royal Australian and New Zealand College issued a statement that detainees should have access to health care "at a level comparable to the general populations of Australia and New Zealand, taking into account the higher prevalence of mental disorders among these groups. This should apply whether they are living in the

community, or held in detention centres either onshore or offshore.” It additionally calls for robust standards and protocols regarding the provision of, and access to, quality mental health care. “Standards should be complemented by appropriate governance and oversight mechanisms, including independent scrutiny and reporting, at least equivalent to that of health and forensic services, which ensure transparency and accountability.” It further recognises the United Nations *Universal Declaration of Human Rights 1948* and the *Convention Relating to the Status of Refugees 1951*, and notes that “Detention facilities should be located in onshore areas where there is good access to high-quality mental health, trauma and physical health services and facilities, and not in remote or offshore locations.” Provision of adequate mental health care, together with a sound quality assurance process that maintains this, is therefore the goal. However, achieving this goal is still within problematic ethical grounds. It has been argued that the provision of any form of health care within detention is advocacy for an untenable environment (Essex, 2019). A relevant issue within the provision of good health care, is the difficulty of separation of responsibility between security of the nation and welfare of the individual, as the two do not necessarily always coincide. Codes of ethics and position statements have been found to have a limited role, however there is a practical approach advocated by a cognitivist’s account of ethical conduct (Dawson, 1994):

“... the hallmark of ethical action, is not the following of a certain rule, but having the flexibility to respond to the unique circumstances of a particular moment. Ethical action is not to be judged by how closely the agent mirrors an abstract set of rules, but by their ability to use the experience they have; to be open to new experience, advice, and criticism; and to be receptive to new ideas, and clients’ and colleagues’ attitudes and opinions ... The idea of moral agency on this view becomes a radically dynamic one, an active seeking of the most appropriate action for those particular circumstances.”

It is in this spirit, therefore, that this review is provided.

Forensic perspectives

There is very little literature providing recommendations regarding the provision of mental health treatment in detention settings. However, there are certain key concepts from forensic literature that can provide guidance in behaviour management. The determination of “dangerousness” (comprising the likelihood of a violent act being committed by the individual) has perhaps the largest number of studies devoted to its assessment and prediction, with ongoing argument regarding same. Psychopathy (as an isolated construct) has repeatedly been identified as one of the best predictors of violence, but other features – such as personality disorders, trauma and substance use – have been noted. Importantly, these components do not all reside within the confines of mental health.

As an assessment tool, the Historical Clinical Risk Management 20 (HCR-20) has emerged as a tool with the best predictive value in identifying the risk of violence. Mental health clinicians will need to be specially trained in order to deploy this tool.

There is ample literature regarding health screening tools used in the forensic system (e.g. the F2169 health screening tool). However, screening tools alone do not provide definitive management, as the subsequent referral process and management is an essential element. The Assessment, Care in Custody and Teamwork process (ACCT) provides an evidence-based process that implements a series of actions to ensure that the risk of suicide and self-harm is reduced. First developed in 2005, it has undergone multiple reviews and enhancements to minimise risk of harm to individuals. Significant issues include the requirement of a multidisciplinary case review meeting within 24 hours of the ACCT being activated – with a key component being the presence of prisoners themselves as being part of case reviews. In a 2015 review this was found to be successful in a qualitative study, with prisoners feeling supported and reassured that staff were there to help them.

Lastly, concerns of confidentiality impacting on care in detained environments is a well-recognised issue. Professor Don Grubin noted this was addressed in the UK within police stations by creating two separate patient records – a police custody record (with minimal information but enough to identify if a person

required medical involvement) and clinical records (kept separately and only accessed by clinicians, that required a court order for police to request access to). It was suggested that a risk matrix for reporting could be implemented to ensure that information regarding individuals posing a risk of harm to themselves or others could be appropriately escalated for broader information, as well as incorporated into a consent process for transparency of engagement.

Assertive vs Intensive Case Management Model

Provision of mental health treatment to individuals on a longer-than-crisis basis progresses towards case management paradigms, which fall between assertive and intensive models of care (Meyer, 2007). An assertive model uses a large, multidisciplinary team with shared caseloads to provide a full range of direct services to consumers; it is a blanket service provision model applied uniformly to all consumers with no tailored components. An intensive case management model encompasses a range of service delivery practices that are not as standardized but targeted, involving assertive outreach, assessment of consumer needs, and negotiation and coordination of care tailored for, and only provided to, specific individuals or groups identified as needing these services. Within large detention populations with limited resources, the assertive model becomes unrealistic; the intensive model in this setting would likely be more efficient and effective.

3.2. Contractual Obligations

The document "Mental Health Procedural Instruction" outlines the current Charter within which all contracted service providers are expected to operate within. As a summary, it includes elements of:

- 1.) Record Keeping
- 2.) Screening and Assessment
- 3.) Challenging Behaviour (including Self-harm and Suicide)
- 4.) Provision of Primary Health Care

Of particular note is the Charter's explicit description of expected model of care. Page 15 notes,

"The DHSP [Detention Health Service Provider] is required to provide primary health care, with the support of a mental health clinician. The mental health clinician will provide psychological support during consultations and refer the detainee to an appropriate clinical specialist service where clinically indicated.

Where clinical specialist services are required, treatment services should be provided by a clinical psychologist..."

4. Review Methodology

The review initially attempted to review management plans for detainees, to assess their compliance and determining an audit process in order to facilitate a quality assurance process. However, it was soon found that mental health services were not being provided to set management plans in a consistent fashion according to Charter. The review then changed to a grounded theory approach.

The grounded theory approach involved interviews with multiple stakeholders in order to assess how mental health services were being deployed within IDFs.

5. Review observations and findings

5.1. Detainee population and Mental Health Services provided

- 5.1.1. The detention population has changed significantly over time since the initial implementation of mental health care review Charter, from a predominantly asylum seeker population to a more forensic population.
- 5.1.2. The reviewers found that services and clinicians were generally well engaged, and keen on positive progress for detainee health and welfare. Services comprised of predominantly welfare-oriented interventions (via SERCO), medical services (via IHMS), security (ABF), and third party services.
- 5.1.2.1. Welfare interventions provided by SERCO are available broadly based on detainee demand, particularly physical exercise-based activities. We have been advised there has been incorporation of some mental health resilience work (although this program was not studied in depth), and the use of a token economy in the form of a points system for community management.
- 5.1.2.2. In addition to GPs, most services had psychiatrists present for one-off assessment on an individual basis. Although provided outlines of models of care suggested they provided isolated opinions, in practice the clinical governance appeared to operate to an assertive model of care, with the psychiatrist present at multidisciplinary case reviews. Services provided are evaluated using the Kessler-10 Psychological Distress Scale (K10), a state anxiety scale with widespread endorsement but very limited clinical value (Andrews G, 2001), as the sole quantitative measure.
- 5.1.2.3. Torture and Trauma counselling is provided for on an individual basis via external providers such as QPASTT, Foundation Health in Victoria.
- 5.1.2.4. The practical delivery of care appears to have been organically developed, responding to needs as they arose. Originally, individuals were case managed with individualised approaches. However, as staffing levels did not rise to meet demand (particularly following a 2014 contract renewal), and due to low turnover of detainees, care is now provided via a crisis management mechanism – all detainees are nominally case managed but not actively followed up, unless deemed a high priority. There is widespread dissatisfaction amongst interviewed frontline staff as a result of this, as it is felt that they are largely reactive rather than proactive and consequently unable to provide effective interventions.
- 5.1.2.5. Despite extensive engagement and investigation, there was little evidence of a quality assurance process contributing to improved care. Compliance with regards to documentation completion is largely quantitative rather than qualitative – meaningful improvements to care did not appear to occur even after critical incidents.
- 5.1.2.6. It is additionally noted that, in the critical need for response to Challenging Behaviour, there is no provision for distinction between “Mental Illness” and “Mental Distress” - that is, individuals exhibiting unwanted behaviour due to the environment of detention and which cannot be addressed by mental health interventions, were receiving multiple mental health assessments with little benefit. This additionally leads to conflict in the potential role for clinicians being involved in endorsing or recommending punitive behaviour.
- 5.1.2.6.1. ***There was initially a primary model of care. Due to difficulties engaging with public mental health services, psychiatrists were eventually obtained to provide mental health***

treatments within the centres themselves. The current model of care is therefore a de facto assertive model with specialist input, and a deviation from the Charter.

- 5.1.3. A relevant service change is the provision of Community Treatment Orders (CTOs). It was previously asserted that individuals on "Federal land" did not fall under "State law" and therefore could not be provided with involuntary community treatment by public services (see: IHMS Western Australia – Management of Community Treatment Orders Summary Paper September 2019). This has since been found to be false in all states with the exception of Victoria, where there are explicit caveats within the Victorian Mental Health Act barring the use of CTOs in the detention space. This means that, with the unfortunate exception of Victoria, other detention spaces are eligible for necessary mental health treatment by public services on an ongoing basis, and the numbers of those on CTOs is steadily increasing.
- 5.1.4. A difficult compromise with regards to the provision of mental health services, particularly with regards to deviation from Charter, arises regarding the degree of interventions that should be provided. More comprehensive mental health services with higher sophistication are necessarily more expensive and cumbersome, requiring more infrastructure. However, simpler services, whilst more streamlined, lead to more dependency on service provision in external community spaces, raising issues of security concerns. On a practical level, there is evidence of inconsistency regarding transfer to external services, with decisions for transfer appearing ad hoc. This is likely related to the aforementioned issue of compromise.
- 5.1.5. The provision and evaluation of welfare services appears limited to detainee preference and attendance. Recruitment of a diversional therapist and implementation of evidence-based interventions to reduce aggression in forensic settings, such as aromatherapy (Wiglesworth, 2016), gardening and pet therapy, may be of significant benefit. It is recognised that individuals are not able to receive accredited qualifications whilst in the detainment space; however, providing them access to skills workshops and other avenues for personal growth (such as basic cooking, studying literature, music) can provide a strong sense of progression and quality of life, due to a sense of acquiring abilities that can be used once leaving the detention space. Similarly, the inability to participate in employment and volunteerism, activities giving meaning to daily life, has been identified as factors causing much frustration amongst detainees.
- 5.1.6. The reviewers found two related elements inherent to current detention life at the core of mental distress experienced by detainees: the indefinite length of detention and limited access to information regarding one's progress in the status resolution process. In addition, case managers were perceived to be ineffective in providing satisfactory updates to detainees. Given that the lack of information and control over one own's trajectory is at the core of mental distress within detention, disengagement with mental health services is largely related to their lack of ability to alleviate mental distress associated with these uncertainties.
- 5.1.7. The availability of illicit drugs within some detention centres has been described as far cheaper and easier than in the general community and within correctional services. Some detainees have their first ever experience of illicit drugs within detention facilities. The reason cited for their pervasiveness is that SERCO does not have the searching rights of Police of visitors or postal

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packages. The usage of illicit drugs within detention are a major contributory factor to challenging behaviour as well as poor mental health amongst detainees.

5.2. Documentation and consent process

- 5.2.1. Documentation, with regards to management plans, comprise three principal elements: the Individual Management Plan (IMP), the Behaviour Management Plan (BMP), and Supporting Monitoring and Engagement (SME).
- 5.2.2. The IMP is managed by SERCO, including basic information regarding the detainee, and very limited information regarding health. The IMPs reviewed had only statements of referral to IHMS services.
- 5.2.3. The BMP is managed by SERCO, with feedback from other services, and cannot be implemented until there is input from IHMS and ABF. In practice, the BMP is less of a management plan and more of a service behaviour contract, with descriptions of punishment consequences and as a deterrent to poor social behaviour. The BMPs are poorly individualised, with medical details provided by a single Health Service Manager (HSM) who rarely has any contact with the individual detainee.
- 5.2.4. The SME is a proximity assessment tool identifying the degree of monitoring an individual deemed to be at high risk of self-harm, suicide or harm to others, should engage. Of note, a significant proportion of the SME mandates levels of monitoring higher than that which would occur in specialist intensive mental health units within hospital settings. When it was suggested that individuals requiring such a level of monitoring should require transfer to a public setting, difficulties accessing public services were cited as a primary difficulty. In addition, it was felt that transfers to a public facility often resulted only in a prompt transfer back, with no mental health admission deemed necessary. Detention centres also feel the pressure to maintain a good relationship with their local public facilities so as not to be seen to be overusing them or doing so inappropriately.
- 5.2.5. Current documentation systems (Apollo EMR, Hydra) are not shared between welfare stakeholders (SERCO/IHMS). Communication is therefore ad hoc and largely verbal, often conducted between individuals and not systemically. Both documentation systems are under ABF governance and monitoring. In practice, it is possible for ABF staff to access information within both, although special business cases need to be established prior to this access. As a result, this limits their usefulness on both fronts – detainees are less likely to be forthcoming on information, and there is no automatic process for critical security-related information obtained from clinicians to be appropriately escalated, although this is possible on an ad hoc basis through submission of a Security Information Sheet.
- 5.2.6. Detainees are advised (correctly) through the consent process that information provided to mental health professionals can affect their immigration status. This may influence the information provided to mental health clinicians, and has led to both extremes of attempted manipulation of the mental health space (as per frontline staff) - detainees fabricating mental health concerns in the belief that it may expedite their claims, or withholding critical information for fear of jeopardising their progress.
- 5.2.7. There is an objective need for a confidential documentation process that is shared between welfare stakeholders, respects detainee confidentiality and at the same time has a reporting risk

matrix in order to protect security of the facility and the broader community, with a transparent legal process for access of information.

6. Management plans

6.1. As previously advised, individuals have multiple management plans with varying intents, input, associated sequelae and review processes (IMP/BMP/SME). However, none of these plans provide guidance regarding the coordinated approach towards individual mental health needs, providing either basic demographics or punitive behaviour contracts. There are additionally conflicts in roles between security provision and medical care provision.

6.2. It is noted that the current interventions are being delivered by IHMS beyond Charter in the form of a limited tertiary service. However, it is recognised that there is a need to provide certain services, including specialist access, to detainees given the recognised elevated mental health burden amongst those in the detainment space (Werthern, 2018).

6.3. There are two separate issues that would be best addressed as separate processes: **Mental Health Plans** and **Challenging Behaviour Plans**.

6.3.1. **Mental Health Plans** should identify an individual's mental health needs, what treatment is being provided, who is providing this, and identify goals and mechanisms for discharge from the relevant mental health services.

6.3.1.1. The current model of care, an assertive model, is unworkable on a longer-term basis given the large number of detainees. An intensive model of care would provide better long-term opportunities and could use limited and existing staff in more efficient ways – for outreach, education, targeted interventions and identifying endpoints for mental health engagement.

6.3.1.2. This can include: Psychological Therapies provided in more cost-effective group-based or online formats, group-based psychoeducation and mental health literacy. Such therapies should address explicitly the mental distress caused by the indefinite length of detention and limited access to information regarding one's progress in the status resolution process. They should provide efforts towards building mental health resilience.

6.3.1.3. Transitioning to an intensive model will provide opportunity for screening approaches (on admission to detainment facilities) to progress more rapidly to targeted interventions – such as identifying those at high risk of violence, or with a history of unresolved trauma.

6.3.1.4. Determining outcomes require more robust tools than the K10. It was noted that current processes involve compliance with RACGP, internal documentation audit, and detainee uptake of interventions without significant resultant procedural change or interventional quality assurance.

6.3.1.5. Creating individualised Mental Health Plans will permit future service audits of these management plans that can be undertaken in future Mental Health Reviews. When these are revised, they can be audited regarding completion, review, frequency of review, and components included.

6.3.1.6. Detainee outcomes can be monitored by internationally recognised interventions, such as the World Health Organisation Quality of Living scale (WHOQOL). This can significantly improve quality assurance processes.

6.3.2. **Challenging Behaviour** has a potential for overlap with mental health issues, but is not necessarily so. In addition, it needs to be recognised that self-harm and suicide risk can exist in the absence of a diagnosable mental illness. The management of Challenging Behaviour

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therefore should be undertaken through a separate process, and documentation should reflect this.

- 6.3.2.1. Using a designated Mental Health Plan will additionally coordinate utilisation of external providers (such as trauma counselling) and permit medical leadership and effective use of case managers.
- 6.3.2.2. This will additionally inform of boundaries of care regarding interservice engagement, and rationale for transition to external services.
- 6.3.2.3. It is noted that elements of the Psychological Support Program (PSP) - KeepSAFE and SME - share significant commonalities with the UK'S ACCT process, with notable exceptions of the separation from explicit mental health governance, as well as the remarkable inclusion of the prisoner (or, in this case, detainee) in the determination of their own plan of intervention.
- 6.3.2.4. In line with the ACCT process, it is suggested to consider integrating a single plan with multiagency engagement and regular review, in accessible electronic documentation system and associated audit approach, informed by forensic behaviour management process. It is also suggested to engage detainees in the process of their own management plans.

7. Recommendations

7.1. Summary of Recommendations

	Topic	Recommendation	Owner
1	Documentation	That two separate EMR structures exist for detention management purposes and clinical management purposes, with an associated risk matrix obligating those documenting in the clinical EMR to report within the detention EMR, to protect patient confidentiality as well as maintain institutional security.	IHMS/SERCO/ABF
2	Consent	That detainee consent form processes be updated to reflect changes in documentation processes, for transparency of engagement with mental health services.	IHMS
3	Model of Care	That the Charter be updated to move from a Primary Care model to an Intensive Case Management Model, with appropriate provisions in terms of numbers and expertise for Specialist mental health services (Psychologists and Psychiatrists), Case Managers, Counsellors, and population-appropriate interventions.	IHMS/ABF
4	Management Plans: Mental Health Plan	That the BMP and SME be replaced with a single Mental Health Plan which are individualised, with entry and exit criteria, clearly stated goals and processes for discharge from active case management. That Mental Health Plan maintenance be incorporated as part of the Charter.	IHMS/ABF
5	Management Plans: Challenging Behaviour Plan	That the PSP and included KeepSAFE and SME components be replaced with a single CBP, with multidisciplinary engagement, detainee involvement, informed by ACCT.	SERCO/IHMS/ABF

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6	Screening and Assessment	That screening processes incorporate evidence-based measures (in addition to unstructured interviews) such as: • HCR-20 • Depression and Trauma scales Documented pathways following positive findings from these measures (and other elements of the interview process) should guide subsequent management and referral to targeted interventions.	IHMS
7	Welfare & Community Interventions	That the Charter be updated to include recommendations regarding Welfare interventions, and quality assurance processes regarding their deployment and monitoring of efficacy. That the legislative limits preventing the engagement in formal education, employment and volunteerism be challenged.	SERCO/ABF
8	Information Provision	That the legal processes, outside the control of the detention facilities, are optimised in terms of efficiency to minimise as much as is possible the length of detention. That the process of accessing information regarding status resolution is reviewed and optimised so as to become meaningful in the alleviation of mental distress of detainees.	DOI/ABF
9	Drugs within Detention	That mechanisms of illicit drug entry into facilities be reviewed and more effective mechanisms put into place to prevent their entry, including the engagement of law enforcement authorities if necessary.	SERCO/ABF

8. References

Andrews G et al, "Interpreting scores on the Kessler Psychological Distress Scale (K10)", Australian and New Zealand Journal of Public Health 2001, vol. 25, no.6

Dawson A. Professional codes of practice and ethical conduct. Journal of Applied Philosophy. 1994;11(2):145–53.

RANZCP College Position Statement 46: The provision of mental health services for asylum seekers and refugees

Werthern M et al, "The impact of immigration detention on mental health: a systematic review" *BMC Psychiatry* volume 18, Article number: 382 (2018)

Mental Health Procedural Instruction (DM-6320, ADD2019/984931)

Meyer P, Morrissey J, "A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas" *Psychiatric Services*, January 2007 Vol.58, No. 1

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). HCR-20: Assessing Risk for Violence (Version 2). Burnaby, British Columbia, Canada, Simon Fraser University. *Mental Health, Law, and Policy Institute*.

IHMS Western Australia – Management of Community Treatment Orders Summary Paper September 2019

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Department of Health First Reception Health Screen (F2169)

The Assessment, Care in Custody and Teamwork (ACCT) process in prison: findings from qualitative research. Ministry of Justice, Sarah Pike and Rachel George, Ministry of Justice Analytical Series 2019

Meeting Minutes: ABF Teleconference June 12, IHMS Psychiatrist June 11, Prof Don Rubin June 11, SERCO June 11, IHMS Quality and Compliance June 11, IHMS Front Line Staff June 16, ABF Officers June 19, IHMS Psychiatrist June 18.

Wiglesworth S, "An Exploration of the Use of a Sensory Room in a Forensic Mental Health Setting: Staff and Patient Perspectives" Occupational Therapy International, September 2016 Vol 23, Issue 3

World Health Organization, "The World Health Organization Quality of Life (WHOQOL)".

https://www.who.int/mental_health/publications/whogol/en/ , accessed 23rd June 2020

9. Approval

Approved By:	
Approved on (date):	

10. Document Control

Version Control	Date	Changes / updates

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Attachment A

Mental Health Care Plan etc

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15 July 2020

Clinical Review Dates	June 2020
Clinical Review Team	Dr s. 11C(1)(a) Psychiatrist Dr s. 11C(1)(a) Emergency Physician
Report preparation	Department's Clinical Advice and Support Provider, Blugibbon.

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HSP	Health Services Provider
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IHMS	International Health and Medical Services
MOC	Medical Officer of the Commonwealth
Officer	A staff member employed by the Department who has met the necessary training requirements to be classed as an officer under the <i>Migration Act 1958</i>
SOP	Standard Operating Procedures
the Department	the Department of Home Affairs
TORs	Terms of Reference
IMP	Individual Management Plan
BMP	Behaviour Management Plan
SME	Supportive Monitoring and Engagement
PSP	Psychological Support Program
EMR	Electronic Medical Record
DHSP	Detention Health Service Provider
ACCT	Assessment, Care in Custody and Teamwork
Charter	Referring to mental health services contracted to be provided as per two reference documents: 1.) Mental Health Procedural Instruction (DM-6320, ADD2019/984931) 2.) Schedule 2 – Statement of Work, Immigration Detention Health Services Contract

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- There is scope for improvement in services, with specific recommendations in the areas of: Documentation, Consent, Model of Care, Management Plans, Challenging Behaviour, Screening and Assessment, and Community Interventions.
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- 2.) IHMS - Medical Director, Director of Operations, Quality Manager, IHMS frontline clinicians including Psychiatrist, Social Worker, Nurses
- 3.) ABF - Detention Officers
- 4.) Detainees – 2 volunteers from Yongah Hill, with experience of mental health services in detention, following an open call for interviews
- 5.) The office of the Commonwealth Ombudsman
- 6.) s. 11C(1)(a) (Internationally recognised expert on forensic behaviour management)

3. Background

3.1. Context

Ethical context

The delivery of care in detention settings is a controversial issue. A systematic review (Werthern, 2018) identified that immigration detention had adverse effects on mental health. The Royal Australian and New Zealand College issued a statement that detainees should have access to health care “at a level comparable to the general populations of Australia and New Zealand, taking into account the higher prevalence of mental disorders among these groups. This should apply whether they are living in the community, or held in detention centres either onshore or offshore.” It additionally calls for robust standards and protocols regarding the provision of, and access to, quality mental health care. “Standards should be complemented by appropriate governance and oversight mechanisms, including independent scrutiny and reporting, at least equivalent to that of health and forensic services, which ensure transparency and accountability.” It further recognises the United Nations *Universal Declaration of Human Rights 1948* and the *Convention Relating to the Status of Refugees 1951*, and notes that “Detention facilities should be located in onshore areas where there is good access to high-quality mental health, trauma and physical health services and facilities, and not in remote or offshore locations.” Provision of adequate mental health care, together with a sound quality assurance process that maintains this, is therefore the goal. However, achieving this goal is still within problematic ethical grounds. It has been argued that the provision of any form of health care within detention is advocacy for an untenable environment (Essex, 2019). A relevant issue within the provision of good health care, is the difficulty of separation of responsibility between security of the nation and welfare of the individual, as the two do not necessarily always coincide. Codes of ethics and position statements have been found to have a limited role, however there is a practical approach advocated by a cognitivist’s account of ethical conduct (Dawson, 1994):

“... the hallmark of ethical action, is not the following of a certain rule, but having the flexibility to respond to the unique circumstances of a particular moment. Ethical action is not to be judged by how closely the agent mirrors an abstract set of rules, but by their ability to use the experience they have; to be open to new experience, advice, and criticism; and to be receptive to new ideas, and clients’ and colleagues’ attitudes and opinions ... The idea of moral agency on this view becomes a radically dynamic one, an active seeking of the most appropriate action for those particular circumstances.”

It is in this spirit, therefore, that this review is provided.

Outline of Priorities

The Independent Health Advisors Panel (IHAP) of the Department of Home Affairs, across multiple iterations of Department Structure and independent advisory roles, as well as visits to onshore and offshore detention environments over 2007-2018, identified multiple previous independent advisory structures and multiple key documents regarding the conduct of onshore mental health services. Relevant for this review were key findings that: IHMS accreditation standards were not defined in contracts previously; IHMS were suggested to utilise an Australian primary care standard for accreditation; there was a need for clinical input into detention health service contracts; there were concerns regarding duration of detention and impact on mental health; the use of restraints in health care settings raised clinical concerns. (See: Independent Health Advisors Panel: Outline of Priorities).

Forensic perspectives

There is very little literature providing recommendations regarding the provision of mental health treatment in detention settings. However, there are certain key concepts from forensic literature that can provide guidance in behaviour management. The determination of “dangerousness” (comprising the likelihood of a

violent act being committed by the individual) has perhaps the largest number of studies devoted to its assessment and prediction, with ongoing related debate. Psychopathy (as an isolated construct) has repeatedly been identified as one of the best predictors of violence, but other features – such as personality disorders, trauma and substance use – have also been noted. Importantly, these components do not all reside within the confines of mental health.

As an assessment tool, the Historical Clinical Risk Management 20 (HCR-20) has emerged as a tool with the best predictive value in identifying the risk of violence. Mental health clinicians will need to be specially trained in order to deploy this tool.

There is ample literature regarding health screening tools used in the forensic system (e.g. the F2169 health screening tool). However, screening tools alone do not provide definitive management, as the subsequent referral process and management is an essential element. The Assessment, Care in Custody and Teamwork process (ACCT) provides an evidence-based process that implements a series of actions to ensure that the risk of suicide and self-harm is reduced. First developed in 2005, it has undergone multiple reviews and enhancements to minimise risk of harm to individuals. Significant issues include the requirement of a multidisciplinary case review meeting within 24 hours of the ACCT being activated – with a key component being the presence of prisoners themselves as being part of case reviews. In a 2015 review this was found to be successful in a qualitative study, with prisoners feeling supported and reassured that staff were there to help them. (See: The Assessment, Care in Custody and Teamwork (ACCT) process in prison document).

Lastly, concerns of confidentiality impacting on care in detained environments is a well-recognised issue. Professor Don Grubin noted this was addressed in the UK within police stations by creating two separate patient records – a police custody record (with minimal information but enough to identify if a person required medical involvement) and clinical records (kept separately and only accessed by clinicians, that required a Court Order for police access). It was suggested that a risk matrix for reporting could be implemented to ensure that information regarding individuals posing a risk of harm to themselves or others could be appropriately escalated for broader information, as well as incorporated into a consent process for transparency of engagement.

Assertive vs Intensive Case Management Model

Provision of mental health treatment to individuals on a longer-than-crisis basis progresses towards case management paradigms, which fall between assertive and intensive models of care (Meyer, 2007). An assertive model uses a large, multidisciplinary team with shared caseloads to provide a full range of direct services to consumers; it is a blanket service provision model applied uniformly to all consumers with no tailored components. An intensive case management model encompasses a range of service delivery practices that are not as standardized but targeted, involving assertive outreach, assessment of consumer needs, and negotiation and coordination of care tailored for, and only provided to, specific individuals or groups identified as needing these services. Within large detention populations with limited resources, the assertive model becomes unrealistic; the intensive model in this setting would likely be more efficient and effective.

3.2. Contractual Obligations

The documents “Mental Health Procedural Instruction” and “Schedule 2 – Statement of Work” outline the current Charter within which all contracted service providers are expected to operate within. As a summary, they include elements of:

- 1.) Record Keeping
- 2.) Screening and Assessment

- 3.) Challenging Behaviour (including Self-harm and Suicide)
- 4.) Provision of Primary Health Care
- 5.) Provision of mental health-related health promotion activities

Of particular note is the Charter's explicit description of expected model of care.

Page 15 of the Procedural Instruction statement notes:

"The DHSP [Detention Health Service Provider] is required to provide primary health care, with the support of a mental health clinician. The mental health clinician will provide psychological support during consultations and refer the detainee to an appropriate clinical specialist service where clinically indicated.

Where clinical specialist services are required, treatment services should be provided by a clinical psychologist..."

Page 22 of the Statement of Work notes:

"7.2.2 The Health Service Provider must consider and use the results or findings of any mental health screening and assessment processes to develop and implement management strategies and treatment plans, as appropriate, for any Detainee who is identified as having, or is at risk of, a mental health concern or issue."

and

"7.2.4 The Health Service Provider must provide and/or coordinate the provision of mental health related health promotion activities for Detainees (for example mindfulness, relaxation, meditation and/or resilience training..."

4. Review Methodology

The review initially attempted to review management plans for detainees, to assess their compliance and determine an audit process in order to facilitate a quality assurance process. However, it was soon found that mental health services were not being provided to set management plans in a consistent fashion according to the Charter. The review then changed to a grounded theory approach.

The grounded theory approach involved interviews with multiple stakeholders in order to assess how mental health services were being deployed within IDFs.

5. Review observations and findings

5.1. Detainee population and Mental Health Services provided

- 5.1.1 The detention population has changed significantly over time since the initial implementation of the mental health care review Charter, from a predominantly asylum seeker population to a more forensic population.
- 5.1.2 The reviewers found that services and clinicians were generally well engaged, and keen on positive progress for detainee health and welfare. Services comprised of predominantly welfare-oriented interventions (via Serco), medical services (via IHMS), security (ABF), and third-party services.
 - 5.1.2.1 Welfare interventions provided by Serco are available broadly based on detainee demand, particularly physical exercise-based activities. We have been advised there has been incorporation of some

mental health resilience work (although this program was not studied in depth), and the use of a token economy in the form of a points system for community management.

- 5.1.2.2 In addition to GPs, most services had psychiatrists present for one-off assessment on an individual basis. Although provided outlines of models of care suggested they provided isolated opinions, in practice the clinical governance appeared to operate to an assertive model of care, with the psychiatrist present at multidisciplinary case reviews. Services provided are evaluated using the Kessler-10 Psychological Distress Scale (K10), a distress scale based on anxiety and depressive symptoms with widespread endorsement but very limited clinical value (Andrews G, 2001), as the sole quantitative measure.
- 5.1.2.3 Torture and Trauma counselling is provided for on an individual basis via external providers such as QPASTT, and Foundation Health in Victoria.
- 5.1.2.4 The practical delivery of care appears to have developed organically, responding to needs as they arose. Originally, individuals were case managed with individualised approaches. However, as staffing levels did not rise to meet demand (particularly following a 2014 contract renewal), and due to low turnover of detainees, care is now provided via a crisis management mechanism – all detainees are nominally case managed but not actively followed up, unless deemed a high priority. There is widespread dissatisfaction amongst interviewed frontline staff as a result of this, as it is felt that they are largely reactive rather than proactive and consequently unable to provide effective interventions. Notably, neither detainee interviewed were even aware of the presence of mental health case managers – stating the only case managers they were aware of were immigration coordinators. Both detainees considered it was their general practitioners who were the managers of mental health treatments. Both also felt that there was limited access to ongoing specialist psychology or nursing engagements, one detainee stating he only had two sessions with a psychologist, and another stating only two telehealth sessions in seven years.
- 5.1.2.5 Despite extensive engagement and investigation, there was little evidence of a quality assurance process contributing to improved care. Compliance with regards to documentation completion is largely quantitative rather than qualitative – meaningful improvements to care did not appear to occur even after critical incidents.
- 5.1.2.6 It is additionally noted that, in the critical need for response to Challenging Behaviour, there is no provision for distinction between “Mental Illness” and “Mental Distress” - that is, individuals exhibiting unwanted behaviour due to the environment of detention and which cannot be addressed by mental health interventions, were receiving multiple mental health assessments with little benefit. This, additionally, leads to conflict in the potential role for clinicians being involved in endorsing or recommending punitive behaviour. As an example, one of the detainees interviewed, who suffers from recurrent suicidality, found that any statement regarding a need for reduced stimulus was met with him being put in involuntary isolation, leading to his mental health interventions appearing more as a form of punishment rather than for clinical support.
- 5.1.2.6.1 **There was initially a primary model of care. Due to difficulties engaging with public mental health services, psychiatrists were eventually obtained to provide mental health treatments within the centres themselves. The current model of care is therefore a *de facto* assertive model with specialist input, and a deviation from the Charter.**
- 5.1.3 A relevant service change is the provision of Community Treatment Orders (CTOs). It was previously asserted that individuals on “Federal land” did not fall under “State law” and therefore could not be provided with involuntary community treatment by public services (see: IHMS Western Australia Management of Community Treatment Orders Summary Paper September 2019). This has since been found to be false in all states with the exception of Victoria, where there are explicit caveats within the Victorian Mental Health Act barring the use of CTOs in the detention space. This means that, with the

unfortunate exception of Victoria, other detention spaces are eligible for necessary mental health treatment by public services on an ongoing basis, and the numbers of those on CTOs is steadily increasing.

- 5.1.4 A difficult compromise with regards to the provision of mental health services, particularly with regards to deviation from the Charter, arises regarding the degree of interventions that should be provided. More comprehensive mental health services with higher sophistication are necessarily more expensive and cumbersome, requiring greater infrastructure. However, simpler services, whilst more streamlined, lead to more dependency on service provision in external community spaces, raising issues of security. On a practical level, there is evidence of inconsistency regarding transfer to external services, with decisions for transfer appearing *ad hoc*. This is likely related to the aforementioned issue of compromise.
- 5.1.5 The provision and evaluation of welfare services appears limited to detainee preference and attendance. Recruitment of a diversional therapist and implementation of evidence-based interventions to reduce aggression in forensic settings, such as aromatherapy (Wiglesworth, 2016), gardening and pet therapy, may be of significant benefit. It is recognised that individuals are not able to receive accredited qualifications whilst in the detainment space; however, providing them access to skills workshops and other avenues for personal growth (such as basic cooking, studying literature, music) can provide a strong sense of progression and quality of life, due to a sense of acquiring abilities that can be used once out of the detention space. Similarly, the inability to participate in employment and volunteerism, activities giving meaning to daily life, has been identified as factors causing much frustration amongst detainees. We note that legislation supporting same is welcomed by the Office of the Ombudsman. (See: Comments from the Office of the Commonwealth Ombudsman).
- 5.1.6 The reviewers found two related elements inherent to current detention life at the core of mental distress experienced by detainees: the indefinite length of detention and limited access to information regarding one's progress in the status resolution process. In addition, case managers were perceived to be ineffective at providing satisfactory updates to detainees. Given that the lack of information and control over one own's trajectory is at the core of mental distress within detention, disengagement with mental health services is largely related to its lack of ability to alleviate mental distress associated with such uncertainties.
- 5.1.7 The availability of illicit drugs within some detention centres has been described as far cheaper and easier than in the general community and within correctional services. Some detainees have their first ever experience of illicit drugs within detention facilities. The reason cited for their pervasiveness is that Serco does not have the searching rights of Police of visitors or postal packages. The usage of illicit drugs within detention are a major contributory factor to challenging behaviour as well as poor mental health amongst detainees. We note that the Office of the Ombudsman has been alerted to this issue, and a "Search and Seizure Bill" addressing these is planned for submission.
- 5.1.8 There was limited evidence of mental health-related health promotion activities as provided by IHMS, although we understood that resilience workshops were apparently being planned to be provided in the near future by Serco.

5.2. Documentation and consent process

- 5.2.1 Documentation, with regards to management plans, comprise three principal elements: the Individual Management Plan (IMP), the Behaviour Management Plan (BMP), and Supportive Monitoring and Engagement (SME).
- 5.2.2 The IMP is managed by Serco, including basic information regarding the detainee, and very limited information regarding health. The IMPs reviewed had only statements of referral to IHMS services.

- 5.2.3 The BMP is managed by Serco, with feedback from other services, and cannot be implemented until there is input from IHMS and ABF. In practice, the BMP is less of a management plan and more of a service behaviour contract, with descriptions of punitive consequences as a deterrent to poor social behaviour. The BMPs are poorly individualised, with medical details provided by a single Health Service Manager (HSM) who rarely has any direct contact with the individual detainee.
- 5.2.4 The SME is a proximity assessment tool identifying the degree of monitoring an individual deemed to be at high risk of self-harm, suicide or harm to others, should engage in. Of note, a significant proportion of the SME mandates levels of monitoring higher than that which would occur in specialist intensive mental health units within hospital settings. When it was suggested that individuals requiring such a level of monitoring should require transfer to a public setting, difficulties accessing public services were cited as a primary barrier. In addition, it was felt that transfers to a public facility often resulted only in a prompt transfer back, with no mental health admission deemed necessary. Detention centres also feel the pressure to maintain a good relationship with their local public facilities so as not to be seen to be overusing them or doing so inappropriately.
- 5.2.5 Current documentation systems (Apollo EMR, Hydra) are not shared between welfare stakeholders (Serco/IHMS). Communication is therefore *ad hoc* and largely verbal, often conducted between individuals and not systemically. Both documentation systems are under ABF governance and monitoring. In practice, it is possible for ABF staff to access information within both, although special business cases need to be established prior to such access. As a result, this limits their usefulness on both fronts – detainees are less likely to be forthcoming on information, and there is no automatic process for critical security-related information obtained from clinicians to be appropriately escalated, although this is possible on an *ad hoc* basis through submission of a Security Information Sheet. We note a statement from IHMS arguing that management plans are currently incorporated into existing medical documentation in the form of notes imputed by a member of the mental health team. (See: IHMS Response to Attachment A – OG 2020/GEN/0007). These, however, do not comprise management plans and are not reviewed nor updated directly as per clinical progress. It was additionally noted that these were difficult to access and not readily reviewed by other treating clinicians, being buried amidst other medical notes, with evidence of psychiatric notes being disregarded by general practitioners reviewing the same patient shortly after.
- 5.2.6 Detainees are advised (correctly) through the consent process that information provided to mental health professionals can affect their immigration status. This may influence the information provided to mental health clinicians, and has led to both extremes of attempted manipulation of the mental health space (as per frontline staff) - detainees fabricating mental health concerns in the belief that it may expedite their visa claims, or withholding critical information for fear of jeopardising their progress (See: IHMS Induction Consent Form - Apollo_MR116).
- 5.2.7 There is an objective need for a confidential documentation process that is shared between welfare stakeholders, respecting detainee confidentiality whilst at the same time being integrated with a reporting risk matrix flagging security risks to the facility or broader community, with a transparent legal process for accessing clinical information.

5.3. Management plans

- 5.3.1 As previously advised, individuals have multiple management plans with varying intents, input, associated sequelae and review processes (IMP/BMP/SME). However, none of these plans provide guidance regarding the coordinated approach towards individual mental health needs, instead providing either basic demographics or punitive behaviour contracts. In addition, they create conflicts between the roles of security provision and medical care provision.

- 5.3.2 It is noted that the current interventions are being delivered by IHMS beyond the Charter in the form of a limited tertiary service. However, it is recognised that there is a need to provide certain services, including specialist access, to detainees given the recognised elevated mental health burden amongst those in the detainment space (Werthern, 2018).
- 5.3.3 There are two separate issues that would be best addressed as separate processes: **Mental Health Plans** and **Challenging Behaviour Plans**.
- 5.3.4.1 **Mental Health Plans** should identify an individual's mental health needs, what treatment is being provided, who is providing this, and identify goals and mechanisms for discharge from the relevant mental health services.
- 5.3.4.2 The current model of care, an assertive model, is unworkable on a longer-term basis given the large number of detainees. An intensive model of care, being target at those deemed in need rather than a blanket approach, would provide better long-term opportunities and could use limited and existing staff in more efficient ways – for example, outreach education, targeted interventions and identifying endpoints for mental health engagement.
- 5.3.4.3 This can include: Psychological Therapies provided in more cost-effective group-based or online formats for psychoeducation and mental health literacy. Such therapies should address explicitly the mental distressed caused by the indefinite length of detention and limited access to information regarding one's progress in the status resolution process. They should provide efforts towards building mental health resilience.
- 5.3.4.4 Transitioning to an intensive model will provide opportunity for screening approaches (on admission to detainment facilities) to progress more rapidly to targeted interventions – such as identifying those at high risk of violence, or with a history of unresolved trauma.
- 5.3.4.5 Determining outcomes require more robust tools than the K10. It was noted that current processes involve compliance with RACGP, internal documentation audit, and detainee uptake of interventions without significant resultant procedural change or interventional quality assurance.
- 5.3.4.6 Creating individualised Mental Health Plans will permit future service audits of these management plans that can be undertaken in future Mental Health Reviews. When these are revised, they can be audited regarding completion, review, frequency of review, and components included.
- 5.3.4.7 Detainee outcomes can be monitored by internationally recognised interventions, such as the World Health Organisation Quality of Living scale (WHOQOL). This can significantly improve quality assurance processes.
- 5.3.5.1 **Challenging Behaviour** has a potential for overlap with mental health issues, but is not necessarily so. In addition, it needs to be recognised that self-harm and suicide risk can exist in the absence of a diagnosable mental illness. The management of Challenging Behaviour therefore should be undertaken through a separate process, and documentation should reflect this.
- 5.3.5.2 Using a designated Mental Health Plan will additionally coordinate utilisation of external providers (such as trauma counselling) and permit medical leadership and effective use of case managers.
- 5.3.5.3 This will additionally inform on boundaries of care regarding interservice engagement, and rationale for transition to external services.
- 5.3.5.4 It is noted that elements of the Psychological Support Program (PSP) - KeepSAFE and SME – share significant commonalities with the UK'S ACCT process, with notable exceptions of the separation from explicit mental health governance, as well as the remarkable inclusion of the prisoner (or, in this case, detainee) in the determination of their own plan of intervention.
- 5.3.5.5 In line with the ACCT process, it is suggested to consider integrating a single plan with multiagency engagement and regular review, in accessible electronic documentation system and associated audit

approach, informed by forensic behaviour management process. It is also suggested to engage detainees in the process of their own management plans.

6. Recommendations

These have been made within section 5. **Review observations and findings** in response to the respective observations and findings of the review. The table below summarises the key recommendations according to the core topics of enquiry within this review.

6.1. Summary of Recommendations

	Topic	Recommendation	Owner
1	Documentation	That two separate EMR structures exist - for 1.) detention management purposes and 2.) clinical management purposes - with an associated risk matrix obligating those documenting in the clinical EMR to report security risks within the detention EMR, to protect patient confidentiality as well as maintain institutional security.	IHMS/Serco/ABF
2	Consent	That detainee consent form processes be updated to reflect changes in documentation processes, for transparency of engagement with mental health services.	IHMS
3	Model of Care	That the Charter be updated to move from a Primary Care model to an Intensive Case Management Model, with appropriate provisions in terms of numbers and expertise for Specialist mental health services (Psychologists and Psychiatrists), Case Managers, Counsellors, and population-appropriate interventions.	IHMS/ABF
4	Management Plans: Mental Health Plan	That the BMP and SME be replaced with a single Mental Health Plan which is individualised, with entry and exit criteria, clearly stated goals and processes for discharge from active case management. It must be regularly reviewed and updated as per the patient's clinical progress. That Mental Health Plan maintenance be incorporated as part of the Charter.	IHMS/ABF
5	Management Plans: Challenging Behaviour Plan	That the PSP and included KeepSAFE and SME components be replaced with a single CBP, with multidisciplinary engagement and detainee involvement, informed by the ACCT.	Serco/IHMS/ABF

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6	Screening and Assessment	That screening processes incorporate evidence-based measures (in addition to unstructured interviews) such as: • HCR-20 • Depression and Trauma scales Documented pathways following positive findings from these measures (and other elements of the interview process) should guide subsequent management and referral to targeted interventions.	IHMS
7	Welfare & Community Interventions	That the Charter be updated to include recommendations regarding Welfare interventions (that is, to bring the Procedural Instruction document in line with Schedule 2), and quality assurance processes regarding their deployment and monitoring of efficacy. That the legislative limits preventing the engagement in formal education, employment and volunteerism be challenged.	Serco/ABF
8	Information Provision	That the legal processes, outside the control of the detention facilities, are optimised in terms of efficiency to minimise as much as is possible the length of detention. That the process of accessing information regarding status resolution is reviewed and optimised so as to become meaningful in the alleviation of mental distress of detainees.	DOI/ABF
9	Drugs within Detention	That mechanisms of illicit drug entry into facilities be reviewed and more effective mechanisms put into place to prevent their entry, including the engagement of law enforcement authorities if necessary.	Serco/ABF

7. References

Andrews G et al, "Interpreting scores on the Kessler Psychological Distress Scale (K10)", Australian and New Zealand Journal of Public Health 2001, vol. 25, no.6

Comments from the Office of the Commonwealth Ombudsman

Dawson A. Professional codes of practice and ethical conduct. Journal of Applied Philosophy. 1994;11(2):145–53.

Department of Health First Reception Health Screen (F2169)

Essex R and Isaacs D, "Responding to mandatory immigration detention: lessons for the health care community" Medical Journal of Australia 2019; 211(9)

IHMS Induction Consent Form - Apollo_MR116

IHMS Response to Attachment A – OG 2020/GEN/0007

IHMS Western Australia – Management of Community Treatment Orders Summary Paper September 2019

Independent Health Advisors Panel: Outline of Priorities

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Meeting Minutes: ABF Teleconference May 19, IHMS Psychiatrist May 22, Prof Don Rubin May 29, Serco June 03, IHMS Quality and Compliance June 05, IHMS Front Line Staff June 12, IHMS Psychiatrist June 17, ABF Officers June 18, Office of the Commonwealth Ombudsman June 30, Detainees June 30

Mental Health Procedural Instruction (DM-6320, ADD2019/984931)

Meyer P, Morrissey J, "A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas" *Psychiatric Services*, January 2007 Vol.58, No. 1

RANZCP College Position Statement 46: The provision of mental health services for asylum seekers and refugees.

Schedule 2 – Statement of Work, Immigration Detention Health Services Contract

The Assessment, Care in Custody and Teamwork (ACCT) process in prison: findings from qualitative research. Ministry of Justice, Sarah Pike and Rachel George, Ministry of Justice Analytical Series 2019.

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). HCR-20: Assessing Risk for Violence (Version 2). Burnaby, British Columbia, Canada, Simon Fraser University. *Mental Health, Law, and Policy Institute*.

Werthern, M et al, "The impact of immigration detention on mental health: a systematic review" *BMC Psychiatry* volume 18, Article number: 382 (2018).

Wiglesworth S, "An Exploration of the Use of a Sensory Room in a Forensic Mental Health Setting: Staff and Patient Perspectives" *Occupational Therapy International*, September 2016 Vol 23, Issue 3

World Health Organization, "The World Health Organization Quality of Life (WHOQOL)". https://www.who.int/mental_health/publications/whogol/en/, accessed 23rd June 2020

8. Approval

Approved By:	Director of Clinical Advice and Support Provider
Approved on (date):	

9. Document Control

Version Control	Date	Changes / updates
1.0		FINAL report submitted to the Department



REQUEST FOR QUOTATION (RFQ)

The Department of Home Affairs (**the Department**) is seeking a quote for Review and reporting outcomes with recommendations in respect of model options of Mental Health care staffing, Services and programs in Immigration Detention setting to be provided by clause 18 (Additional Services) under the contract signed between Blugibbon and Department of Home Affairs on 9 September 2020 including contract variation dated 23 March 2020.

The quote should be received before COB 23 April 2020.

Background information:

On 11 December 2014, the Department entered into the Immigration Detention Health Services contract (the IDHS Contract) with International Health and Medical Services (IHMS) for the provision of primary health (including mental health) care services to the detainees in the onshore Immigration Detention Network (IDN).

The IDHS Contract with IHMS ensures that the detainees have access to health assessments, investigations, treatments, procedures or other clinical health services to a standard broadly commensurate with health care available to people in the Australian community through the public health system. This includes the provision of clinic facilities and integrated primary health care, including appropriate mental health clinical care and complex case management, in addition to health information and advice and health promotion and disease-prevention activities.

IHMS is required to provide primary health care with the support of a mental health clinician. The mental health clinicians provide care during work hours. More complex cases and after hours, cases may be referred to external service providers as needed. . This process lacks the flexibility for early intervention and treatment of complex mental health cases.

Over the past three (3) years, there has been a significant change in the Immigration Detention Network (IDN) population demographic. This has led to changes in the complexity and management of mental health needs, including continuity of care, upon entry to detention and early intervention.

Any impact on the ability to deliver early intervention programs for detention cohort including those with complex mental health needs, is likely to influence client wellbeing and options for resolution of the detention status i.e. continued detention, removal to home country or grant of a visa and hence release from detention.

Requirement:

This request for quotation is to:

- Review the statement of work related to clinical mental health care services and programs in the IHMS contract;
- Review the IHMS mental health care model, including staffing, clinical services and programs and compare their consistency with the statement of work in the IHMS contract;

- Compare the statement of work (IHMS contract), IHMS mental Health care mode clinical services and programs, and Departmental Mental Health Procedural Instruction for inconsistencies between the three.
 - Conduct a high level review of the mental health clinical caseload (*insert a range of numbers based on 5 to 10% of the current caseload*) up to a maximum of 75 cases as well as the quality and adequacy of clinical documentation. The review caseload will be selected from a range of complexity levels, population and geographic demographics. The review should also provide a clear definition to identify 'complex mental health cases'.
 - Review any other aspects of mental health settings in immigration detention that are required to support any recommendations.
 - Provide recommendations as per the section on Documentation below.
- Optional:** (please provide a separate quote)
- Review IHMS' Psychological support Program (PSP) and compare with PSP provisions in the Departmental Mental Health Procedural Instruction.
 - Provide recommendations to improve the PSP model and services.

Documentation

Blugibbon is required to provide a comprehensive report detailing:

- The review methodology and outcomes of the review of items listed in the Requirements;
- Recommendations on improving items listed in the Requirements i.e model options for mental health care staffing, services and programs, model options for management of complex mental health cases and provide engagement strategies for managing those who may be disengaged with health care services.
- Recommendations that provide model options for continuity of mental health care on entry to detention as well as early intervention.
- Recommendations that are:
 - a) consistent with the requirements of relevant Australian mental health standards,
 - b) evidence based; and
 - c) practical from an implementation perspective.
- The report must be written in plain English to enable non-clinicians to understand so that they can make informed decisions regarding contracted models of mental health care.

Performance Standards

As per contract. Additionally, the Services are to be provided by a Specialist Clinician and/or Specialist Team with substantial experience and a high level of competence in reviewing mental health programs and proposing improved clinical outcomes preferably in a custodial/correctional environment and providing robust recommendations that are achievable and able to be implemented. All recommendation must be evidence based.

Methodology

The Specialist Clinician and/or Specialist Team are to submit a proposed methodology of the review with the quote.

Location of Work:

The Services will be delivered at the supplier's location with meetings to be held at the Department's offices at, 3 Molonglo Avenue, Brindabella Business Park, ACT or 300 Elizabeth Street Surry Hills NSW

Information Required:

Supplier must complete Attachment A – Standard Form of Quotation attached and provide all the information as detailed.